

**FIVE PROFESSIONAL PRACTICE REPORTS FOCUSSING ON
SIGNIFICANT AREAS OF EDUCATIONAL PSYCHOLOGY
PRACTICE
(VOLUME TWO)**

BY

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CHAPTER ONE

VOLUME ONE: INTRODUCTION AND OVERVIEW

VOLUME TWO: INTRODUCTION AND OVERVIEW

1. The Role of the Trainee Educational Psychologist

In September 2006 the newly agreed training route for Educational Psychologists (EPs) commenced, marking the end of the one year Masters course and the beginning of the three Year Doctorate programme. As part of the Applied Educational and Child Psychology Doctorate programme students are required to secure an appropriate supervised placement working within a Local Authority Educational Psychology Service (EPS) for years two and three of the course. I was employed by a large West Midlands Local Authority (LA) and worked as a Trainee Educational Psychologist (TEP) in the south area of the LA under the supervision of two experienced EPs. As part of my dual role as a TEP, employed by a LA and a full-time student enrolled on a doctoral course, I was obliged to meet the, sometimes disparate, requirements of both the EPS and university, carrying out the role of an EP within six schools, whilst also trying to negotiate, and fit in, a number of diverse learning experiences and identify projects or work which could form part of a research study or professional practice report. There were also challenges and uncertainties resulting from being the first cohort of TEPs enrolled on the doctoral training; this sometimes lead to the feasibility and requirements of our roles within the LA being worked out as the course progressed.

My responsibilities and independence in fulfilling the role of TEP were gradually increased over the two years I was employed by the EPS. Initially I carried out joint work with my

supervisors; however in the third year of training I acted as the visiting EP in six schools, negotiating casework, training and statutory work.

I joined the EPS at a time of change when the service was redefining its role within schools and the LA, emphasising its identity as a team of applied psychologists who could offer schools and extended provision clusters advice and guidance in relation to the use of evidence-based practice. Schools had been advised that EPs were best placed to work preventatively, carrying out a range of whole school, class and small group interventions, as well as training and consultation with staff and parents. This new way of working suggested that EPs restrict the individual casework they took on to cases where a unique psychological contribution could be identified and where there was the opportunity to develop the skills of staff. This 'refocusing' of the EPS was discussed with the six schools to which I had been allocated during the first planning meeting of the school year 2007-8, and met some resistance from SENCOs and senior staff, as the decision to reduce the time given to schools by a small amount, in order to support cluster level work, was introduced simultaneously.

The concept of EPs working preventatively in schools and moving away from individual referrals in order to improve educational outcomes for a greater number of children is neither novel nor unique to the LA by which I was employed. A report by the Department of Education and Employment (DfEE) in 2000 described the EP role as,

to promote child development and learning through the application of psychology by working with individual and groups of children, teachers and other adults in schools, families, other LEA officers, health and social services and other agencies. (DfEE, 2000, p.5)

Farrell et al (2006), in their report on Educational Psychology Service delivery in England and Wales suggest that changes brought about by legislation such as Every Child Matters (DfES, 2004) had led to the EP role evolving further to include multi-agency working. Cameron (2006) asserts that the profession of Educational Psychology is currently experiencing an identity crisis, due in part to the number of other professionals who provide similar services to those provided by EPs, and the need to 'achieve a measure of professional distinctiveness'. It is within this context of uncertainty and change that I have completed the new route of Doctoral training, a change which Cameron (2006) suggests further compounds the identity crisis within the EP profession, and it is in this context that the examples of EP work, described in my professional practice reports, are based.

2. Working within a West Midlands Local Authority: Contextual Information

The West Midlands Local Authority in which I worked as a TEP is England's largest urban authority, with a population of approximately a million people (Ofsted, 2007). It is recognised as a diverse community in many ways, in terms of different ethnicities, cultures and levels of prosperity and well-being. In the Joint Area Review of the LA's Children's Services Ofsted (2007) describe parts of the city and its communities as

'having high levels of deprivation, with the associated problems of crime, poor health and unemployment'. p. 5

Even before the economic downturn in 2009 the 2001 Census (Office for National Statistics) recorded unemployment levels within this LA as being significantly higher than the national

average. Nearly 30% of the population are from minority ethnic communities, the largest community being south Asian, with approximately 14% of people identifying themselves as Muslim (Office for National Statistics, 2001).

This LA also has a higher proportion of young people than average; with over half of pupils coming from minority ethnic communities and 30% coming from one parent households, compared, in this latter case, with a national average of 6.5% (Ofsted, 2007). There are 178,000 pupils within the LA: 4000 are registered disabled (Ofsted, 2007), 40,000 have been identified as having special educational needs, 7000 have statements and 3000 attend special schools (BCC, 2007).

The Local Authority Children's Services reflect the size, diversity and level of need within the community, with the EPS employing the equivalent of 52 full time EPs, seven TEPs and six graduate psychologists. Children's Services within this LA are not currently constituted as co-located multi-agency teams: a practice which some of the surrounding LAs have adopted. Instead each service functions independently, endeavouring to ensure task-focused 'joined up working' on individual cases, and within schools and extended provision clusters.

The cluster within which my six schools were based is an inner city area of relatively high social disadvantage. I took on the role of visiting EP in four primary schools, one secondary boys' school and one primary special school for children with moderate learning difficulties.

3. Overview and Rationale for the Professional Practice Reports

The University provided guidance on the structure of professional practice reports (PPRs) and broad areas on which they should focus; however as stated in Section 1, the focus of work which would inform the PPRs had to be feasible within service employment requirements and so, where possible, had to develop from naturally occurring opportunities within service delivery. Of the five PPRs I have written, two fall within the ‘areas’ of complex individual needs (PPR 1) and evaluation of group work (PPR 2) suggested in the university guidelines; however the other three were developed in response to the type of work I was carrying out within my schools, and so fulfilled the role of informing my current practice and increasing my knowledge base for future practice.

PPR 1 focuses on the use of the term ‘Attachment Disorder’ and critically evaluates the research evidence for its use as a diagnostic label with reference to a case study of a child with complex needs, for whom this term is often used. There were two main reasons why I chose to focus on the use of the diagnostic category of ‘Attachment Disorder’: firstly it was a term I had heard used frequently by a number of professionals when describing children with emotional and behavioural difficulties, often when there no diagnosis had been made by a suitably qualified mental health practitioner, and secondly because in my role as visiting TEP for a special school I had been involved in monitoring the progress of a pupil (Child A) who had been diagnosed, amongst a number of difficulties, with an Attachment Disorder.

This report reviews the theoretical and evidence bases for attachment theory (Bowlby, 1969) and attachment classifications (Ainsworth, 1978) and critiques the DSM-IV diagnosis of

Attachment Disorder (American Psychiatric Association, 1994). Research on meeting the needs of children with attachment difficulties and / or disorders in school is reviewed with reference to EP practice, and the report concludes by suggesting that ill-informed use of this label, and the research underpinning it, may have the negative effect of limiting the expectations adults hold for children.

The aims of **PPR 2** were to review the evidence on which behavioural parenting programmes are based and to identify from within the research which practical, content and client-based factors influence the outcomes of parenting interventions. I chose this focus for PPR 2 in response to my own experience of running a Triple P Parenting Programme, presented as a case study within the report, and because of media discussions on the role of parenting and the government's introduction of parenting orders through the Anti-Social Behaviour Act (Home Office, 2003), which can be used to direct parents to attend such courses. The report highlights the dilemma of presenting a course which is relevant and accessible to parents with differing levels of education and from different cultures, whilst maintaining fidelity of intervention.

The report concludes with reflections on the changes which could be made in order to increase the effectiveness of a parenting course within a similar parent group, and suggests that there is a need for further research into what specific aspects of parenting interventions are best suited to the needs of hard to reach groups.

PPR 3 evolved from working with an individual child identified by an all girls secondary school as at imminent risk of permanent exclusion because of her challenging behaviour.

Working with the young person on a one to one basis over a number of weeks highlighted contradictions in the way her behaviour was being managed by members of staff and a number of areas where the school's behaviour policy could be more effective. Although these concerns were shared with the relevant members of staff and the offer of support made by the EPS in relation to developing behaviour policy, the school did not prioritise this as an area for EP work.

This report reviews the literature on how the role of the EP has developed in England from focussing on individual cases to working more preventatively and effectively within schools. The background to and key concepts of General Systems Theory (von Bertalanffy, 1968) are outlined and these concepts are then applied retrospectively to the case study in order to inform understanding of why the school chose not to act on the suggestions made by the EPS at either an individual or systems level. The report concludes by reflecting on the helpfulness of systems approaches and the challenges EPs face when trying to bring about systemic change within schools.

I choose to focus on parents' perceptions of Attention Deficit-Hyperactivity Disorder (ADHD) in **PPR 4** because of the relatively high number of children I worked with as a TEP where the diagnosis of ADHD was suggested by parents, teachers or other professionals involved in the case. ADHD is also a disorder frequently covered by the media and one which often evokes strong opinions and the expression of disparate understandings amongst professionals.

The report starts by summarising research on ADHD, its defining symptoms, theories on its causes, epidemiology and methods of diagnosis and treatment. The report then considers

research on parents' understanding of their child's ADHD and their experiences of its diagnosis and treatment and how it affects their family life. Two cases studies are presented of boys at primary school who have been diagnosed with ADHD and whose parents have differing views on how it should be treated. These case studies are referred to when the role of the EP in working with children with ADHD, their parents and schools, is considered. In light of research which asserts that parents find the contrasting views of ADHD held by professionals both confusing and stressful (Norris and Lloyd, 2000; Harborne et al, 2004) this report concludes by suggesting that the presentation of a bio-psychosocial account of ADHD (Frith, 1992; Cooper 2001) by EPs may reduce the frustration experienced by parents and improve outcomes for children by emphasising the value of multi-modal assessment and treatment.

Finally **PPR 5** focuses on the role of the EP in contributing to the statutory assessment of children with special educational needs. This PPR was written during a period where I had a relatively high number of psychological advices to write, thus limiting the amount of other work I was able to carry out within schools and the cluster. It reports the views of key stakeholders (parents, children and SENCOs/teachers) in six cases studies, expressed during interviews/discussions with myself, where information was collected to inform psychological advice.

The report provides a brief summary of the concept and history of special educational needs in England and the legislation which shapes the current practice of issuing statements. Research on the criticisms of statutory assessment in relation to how inclusive statements are, their cost and their effectiveness in the equitable use of resources are summarised. The views

of those in the case studies are then discussed in relation to the scarce amount of existing research on stakeholders' views of statements and the research on the disadvantages of the current system of statutory assessment. The report concludes by reflecting on the contrast between the hopes of stakeholders in the case studies and the research findings on parents' perceptions of the statutory assessment process and its outcomes.

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CHAPTER TWO

A CRITICAL ANALYSIS OF THE USE OF THE LABEL

‘ATTACHMENT DISORDER’: THE IMPLICATIONS FOR CHILDREN IN SCHOOL AND EDUCATIONAL PSYCHOLOGY PRACTICE, WITH REFERENCE TO AN ILLUSTRATIVE CASE

A CRITICAL ANALYSIS OF THE USE OF THE LABEL
‘ATTACHMENT DISORDER’: THE IMPLICATIONS FOR CHILDREN
IN SCHOOL AND EDUCATIONAL PSYCHOLOGY PRACTICE, WITH
REFERENCE TO AN ILLUSTRATIVE CASE.

Abstract

The term attachment disorder is often used within schools and amongst professionals working with children and young people, and the implications of attachment theory are recognised in new government guidance such as Care Matters: Time for Change (DfES, 2007). This report will give an overview of attachment theory and some of the research areas that have developed from it. With reference to the illustrative case of Child A it will discuss the contentions that surround the diagnosis of Reactive Attachment Disorder and the limitations of attachment theory and its research bases. Finally this paper will argue that limited knowledge about attachment theory, and the body of research that underpins it, creates assumptions about what children can achieve and limits the expectations significant adults in their life may hold for them.

A CRITICAL ANALYSIS OF THE USE OF THE LABEL
‘ATTACHMENT DISORDER’: THE IMPLICATIONS FOR CHILDREN
IN SCHOOL AND EDUCATIONAL PSYCHOLOGY PRACTICE, WITH
REFERENCE TO AN ILLUSTRATIVE CASE.

1. Introduction

Child A is 7 years old and attends a local Special School for children with Moderate Learning Difficulties for which the author is the visiting Trainee Educational Psychologist. He has been known to the Educational Psychology Service since 2004 when he started attending the nursery of a mainstream school. He continued into reception at the same school during which time a Statutory Assessment was carried out on the basis of his social, emotional, behavioural, learning and medical needs. Following a multi-agency annual review in 2006 Child A was moved to a Behaviour Assessment Centre where he remained until he began his induction period in 2007 at his present specialist placement.

Although presently the author is not the named EP responsible for the Educational Psychology Service’s work with Child A the objectives of their involvement have been to become familiar with his educational history and his current needs through observation of him in the classroom and consultation with his teacher. The author was introduced to this case because of the complexity of Child A’s developmental difficulties and the possibility that the school may require further support in meeting his needs, particularly as he had just started in a new classroom with unfamiliar teaching staff.

Child A has been diagnosed with a number of difficulties that impact on his behaviour and learning, one of which is attachment disorder (see Section 3.6). With reference to attachment theory and research and the DSM-IV Criteria for Reactive Attachment Disorder (American Psychiatric Association, 1994) this report will consider the following questions:

1. How useful is the diagnosis of an attachment disorder in informing the support and provision that Child A requires in his educational setting?
2. How relevant is attachment theory and research to Educational Psychologists' practice?
3. What are the risks and benefits for a child who is identified as having an attachment disorder?

2. Attachment Theory

Attachment theory is recognised as one of the major developmental paradigms for understanding human social and emotional development. It combines both psychoanalytic and biological approaches to explain the impact of early childhood relationships on personality, behaviour and development. John Bowlby, regarded as the 'father' of attachment theory, trained as a child psychiatrist having worked as a volunteer in a school for maladjusted children. It was this experience and those that followed in a London Child Guidance Clinic, and latterly in the Tavistock Clinic that developed Bowlby's interest in the family lives/experiences of the children he worked with (Goldberg, 2000). When Bowlby first began

to write about attachment in the 1940s it contrasted with other popular theories in its conceptualisation of the role of the caregiver and the significance of this relationship in forming infant's beliefs about themselves and others. Other theories focussed on the role of the caregiver in reducing physiological arousal (psychoanalytical theory) and in teaching (learning theory), whilst attachment theory suggested that the caregiver should be a provider of safety and protection (Goldberg, 2000). Bowlby believed that children are born with instinctive behaviours that elicit a care-giving response from adults, and that the stimulus-response patterns of behaviour between a care-giver and baby result in the child forming a specific bond with that adult,

‘the propensity to make strong emotional bonds to particular individuals [is] a basic component of human nature, already present in germinal form in the neonate.’
(Bowlby, 1988, p.3.)

Ainsworth et al, (1978) describe the child- caregiver attachment as an active, affectional and reciprocal bond that emerges from repeated interactions over time and which remains relatively stable.

Bowlby (1969) suggested a three phase model for the development of the infants' attachment with a genuine attachment being formed from 6 months of age as the child begins to understand that objects and people exist when out of sight. As the child develops confidence in the caregiver's physical and psychological availability she/he is then able to use the primary care-giver as a secure base from which to explore the world. Attachment can not be observed directly because it is an internal state; however deductions can be made about attachments by observing attachment behaviours which are elicited when the infant is in need of care or support.

2.1 Attachment Classification

Ainsworth, working with her colleagues, (1978) developed the Strange Situation Procedure following a period of time in the 1950s studying infant-mother attachment in Uganda and then in Baltimore, North America. Ainsworth noticed differences in the distress provoked in Ugandan and American infants through separation from their mother and set out to explore this further by developing an observation measure consisting of a number of structured separations and reunions (Goldberg, 2000). The Strange Situation Procedure was the first, and remains, one of the few standardised and validated measures of infant-parent relationships. It instigated research into attachment and formed the basis for the development of other measures of attachment in childhood and adulthood (Goldberg, 2000). The Strange Situation Procedure (SSP) can be carried out with infants aged between 12 to 18 months. It consists of a series of eight episodes where the infant, mother/ primary caregiver and a stranger are present in a number of different combinations (see Table 1). Each episode lasts for three minutes and becomes increasingly stressful in order to elicit the infant's attachment behaviours which are observed and recorded by the observer.

Table 1: Episodes of the Strange Situation

(Adapted from Ainsworth et al, 1978 and Goldberg, 2000)

Episode	Participants	Description
1*	Mother, baby, experimenter	Experimenter brings mother and baby to the room and gives instructions
2	Mother, baby	Mother sits in chair and reads, baby explores, Mother responds if approached but does not initiate interaction
3	Mother, baby, stranger	Stranger enters (silent 1 minute), conversation with mother (1 minute), approaches baby (1 minute)

4	Baby, stranger	Mother departs (first separation), stranger comforts baby if needed, otherwise sits on chair.
5	Mother, baby	Mother returns (first reunion), Greets and /or comforts baby, sits on chair and reads
6	Baby	Mother departs (second separation), saying 'bye-bye'
7	Baby, stranger	Stranger enters, comforts baby if necessary, otherwise sits in chair
8	Mother, baby	Mother returns (second reunion) greets baby and/or comforts if needed, then free to interact how she chooses.

* Duration is less than 3 minutes

Ainsworth and her colleagues (1978) observed patterns of behaviour that could be classified into the two categories of secure and insecure attachment. Securely attached infants used their primary caregiver as a secure base from which to explore the new room and play with the toys. They were upset by their parent's departure but were easily consoled upon his/her return. Insecure attachment behaviour could be further categorised into insecure detached/avoidant and insecure resistant/ambivalent. Typically infants categorised as insecure detached/avoidant showed little preference for their mother over the stranger, they were not distressed when she left the room and ignored her on her return. The infants judged to be insecure resistant/ambivalent appeared to be preoccupied with their mother and reluctant to explore the new situation. They became extremely distressed at their mother's departure but resisted being comforted on her return.

A fourth category was added to the attachment classifications when Main and Solomon (1990) undertook a review of videotapes of infants whose behaviour in the strange situation failed to meet the criteria for any of the three existing categories. The behaviour displayed by these infants did not reveal a new pattern but rather sequences of odd behaviour that did not seem to

have an obvious purpose or goal. These unusual behaviours suggested that the infant has confused expectations or was fearful of the caregiver. This fourth category was called disorganised/disorientated attachment because the infant appears to have no strategy for relating to the caregiver, or an ineffectual or unreliable strategy, resulting in unusual behaviours such as approaching the caregiver, then freezing and looking away or avoiding the caregiver when distressed and crying, but being unable to comfort him/herself.

2.2 Origins of Secure and Insecure Attachments

Much of the research into attachment relationships focuses on the role the primary caregiver has in shaping attachments. Although relationships require contributions from two individuals, most developmental theories emphasise the importance of the parent's role in the infant's development (Bee & Boyd, 2007). In her work preceding the Strange Situation, Ainsworth (1977, cited in Goldberg, 2000) carried out intensive home observations of mothers and their infants and described three attachment patterns that paralleled the later named secure, resistant and avoidant classifications. She rated the mothers according to their availability, amount of physical contact and sensitivity to infant signals, and found those who were most sensitive to their child's signals were more likely to have securely attached babies, whilst mothers of infants classified as avoidant (not yet attached) had low ratings for maternal availability and physical contact. These results supported Ainsworth's hypothesis that it is the interaction between mother and child that is responsible for the differences seen in infant-mother attachment relationships (Ainsworth et al, 1978).

Research into parent-child interaction has suggested that the emotional availability of the caregiver is one of the main influences on the formation of a secure attachment with the child

(Biringen, 2000). Other studies assert that the caregiver's acceptance of the infant and sensitivity to his/her needs is also important, requiring the parent to be attuned to the child's signals and to respond appropriately to them (De Wolff & Van IJzendoorn, 1997). Disorganised/disorientated attachments have been shown to be prevalent where the child has been abused or the parents have suffered trauma, such as abuse by or death of a parent, in their own childhood (Cassidy & Berlin, 1994; Main & Hesse, 1990). Venet et al (2007) found there was a significantly higher proportion of avoidant attachments in a sample of neglected children when compared with a control group matched for gender and age, and that this remained significant even when socio-economic status and maternal stress were controlled for. Research has shown that the ambivalent attachment pattern is found where the mother's emotional availability to the child is inconsistent, often because of depression or drug/alcohol abuse (Teti et al, 1995) whilst the avoidant pattern can be the result of regular rejection and withdrawal by the mother (Bee & Boyd, 2007).

2.3 Internal Working Models

Bowlby used the term 'internal working model' (IWM) to describe the mental mechanism through which early experiences are carried forward to influence relationships beyond childhood and the primary caregiver. This working model is an internal representation of the attachment relationship between the infant and caregiver whose behaviours reflect and maintain this relationship (Goldberg, 2000). Bowlby (1969) asserts that an infant's internal working model of attachment is formed late in the first year of life, becoming further elaborated and established over the following four to five years. According to Bee and Boyd (2007) by five years of age most children will have an internal model of their primary caregiver, a self-model and a model of relationships. These models contain expectations for

sequences of behaviour, rules for behaviour with others and interpretation of others' actions. They are used to make sense of experiences and influence memory by directing what a child attends to and what they remember (Kirsh & Cassidy, 1997). IWMs form the basis of the developing child's expectations of the dependability and responsiveness of others, both within and beyond the family. They are viewed as influential in cognition, language, affect and behaviour through their role in the development of strategies for coping with stress and seeking social support (Cicchetti et al, 1995).

A major criticism of IWMs is the lack of information that is known about them (Goldberg, 2000). Internal Working Models can not be directly observed; rather inferences are made from their 'products', such as social behaviours and beliefs, self-reports/narratives and drawings. Bretherton and Munholland (1999) reviewed existing research on IWMs and concluded that more information is needed concerning how they develop and integrate new experiences, and how they manage discordant attachments with different care-giving figures as infants and latterly in adult relationships.

2.4 The Effects of the Attachment Relationship

Ainsworth's attachment classifications have been used widely in research and have been found reliably to predict a range of behaviour in children (Goldberg, 2000). The Minnesota longitudinal Parent-child study followed a group of several hundred infants through childhood and adolescence (Sroufe et al, 1993; Urban et al, 1991; Weinfield et a, 1997) and found that during a summer camp teenagers in early adolescence who were classified as secure in infancy were rated as higher in self confidence and social skills, and made friends more easily than their peers who were insecure in infancy. The majority of adolescents with a history of

insecure attachment showed behaviours such as isolation from peers, passivity, hyperactivity or aggression.

When researching the influence of attachment classification on school-age outcomes, Lyons-Ruth et al (1997) assessed attachment in a sample of infants aged 18 months using the Strange Situation Procedure and then compared this with teacher and parent behaviour reports at the age of seven years. They found that infants who displayed avoidant attachment behaviour showed high levels of internalising behaviour at age seven, whilst infants who displayed disorganised behaviours demonstrated high levels of externalising behaviour. There is a strong relationship between attachment classification and later social, emotional, behavioural and academic outcomes. Securely attached pupils are more likely to view themselves as competent, show higher levels of participation and attention in class and achieve higher grades whilst pupils with a resistant attachment style may lack self-confidence and become isolated from their peers (Jacobsen & Hoffmann, 1997). Children with an avoidant attachment style often use ineffective strategies when stressed and resist seeking help from their peer group (Larose and Bernier, 2001).

With the aid of recent developments in neuroscience, primary attachment relationships have also been linked with the development of the brain in infants. While a comprehensive review of this evidence will not be attempted within the confines of this report; I will briefly outline one focus of the neuropsychological research. Schore (1996, 2000) described behavioural exchanges between the care-giver and infant in terms of the influence of one brain upon another. He focussed on brain development processes which are 'experience-dependent',

where specific events result in the generation of new synaptic connections. Geddes (2006) summarises this process,

‘Connections and pathways develop in response to stimulus and experience and lay the foundations for later responsiveness.’ (p. 42)

Schore (2000) describes how face-to-face interactions between the baby and care-giver create a context where a system within the prefrontal cortex of the baby’s brain, which is involved in homeostatic and attachment functions, matures and develops. In simplified terms Schore states that smiles and ‘loving’ looks from the primary attachment figure stimulate the production of biochemicals which help the baby’s neural pathways to develop. Although a large body of evidence exists in this area from animal studies it still offers only a speculative model (Goldberg, 2000); however Geddes (2006) asserts that it has implications for understanding how children with attachment difficulties manage stress and anxiety.

Many of the effects of insecure attachment relationships presented above can be identified in the case study of Child A, whose additional needs are cognitive, emotional and behavioural. However in Child A’s case, as with many other children, it is difficult to make causal links between his attachment difficulties and the needs described below because of the many other factors that have been and still are influential on his development, such as medical conditions and the implications of significant experiences and life circumstances.

3. An Overview of Child A

3.1 Formulation of Needs

Child A has complex needs and is involved with a number of professionals. Because of this it has proved challenging to search back through his records to determine how his needs had been formulated over the past seven years and by whom. Child A's educational psychology file contains reports which have been produced in order to contribute to his Statutory Assessment, rather than detailed records of the number and types of contact different services have had with him and/or the knowledge bases which professionals involved in A's care and education had used to inform their formulations. Table 2 contains a synthesis of information that was presented in the professional reports which contributed to the formulation of Child A's needs.

The main professional services that have contributed to assessing Child A's needs include: Child and Adolescent Mental Health Services, Educational Psychology Service, Behavioural Support Services, Speech and Language Therapy and Occupational Therapy.

Table 2: Relevant information contributing to the formulation of Child A's needs

Aspects of Development and Functioning	Relevant information recorded in Child A's file
Early developmental history	<ul style="list-style-type: none">• Born drug dependent• Intensive medical intervention for the first 15 days of life• Overfed and underfed by biological mother• Fostered, then adopted at the age of one year

Physical health and development	<ul style="list-style-type: none"> • Failed 18 month health check on 2 occasions: excessive drooling, poor sleeping, delayed speech and poor fine motor skills recorded • From the age of two, Child A suffered from severe toddler diarrhoea; he often soiled or wet himself and on occasion reportedly smeared his faeces. • At 4 years described by parents as having disturbed sleep, difficulties with fine motor skills and toileting, poor concentration and high activity levels.
Social, Emotional and Behavioural Needs (at age four, as described by his adoptive parents)	<ul style="list-style-type: none"> • moans and cries a lot, frequently demanding attention from them • appears not to have developed an emotional bond with parents, his siblings or his belongings • Behaviour is difficult to manage with frequent and lengthy temper tantrums and acts of aggression such as biting or hitting. • Shows severe separation anxiety and a fear of strangers, but does not use his parents for comfort when distressed • Prefers to play alone, rarely plays imaginatively • Use of language for social communication is poor • Does use eye contact to engage a person before speaking to them but finds it difficult to show an appropriate variation in emotional expression
Unusual Interests and Behaviour	<ul style="list-style-type: none"> • Becomes distressed when his routines are broken • Fascinated by football

(at age four, as described by his adoptive parents)	<ul style="list-style-type: none"> • Hypersensitive to loud noises • Smells food inappropriately
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3.2 Diagnosis and Intervention

On the basis of the above information Child A was diagnosed with a High Functioning Autistic Spectrum Disorder (ASD) in Autumn 2005. The Consultant Psychiatrist who made the diagnosis also suggested that Child A had Attention Deficit Hyperactivity Disorder (ADHD), but required a Conners' Rating Scale to be filled in by the school and parents in order to confirm this. Preceding these diagnoses a report was written by a Clinical Psychologist who emphasised the complexity of Child A's case and the challenge of attributing his behaviour to an attachment disorder or ADHD and ASD because of the overlap in difficulties associated with these conditions. However throughout Child A's file the term attachment disorder is used frequently by professionals to describe his needs and the resulting treatment that has been identified is three sessions of psychotherapy per week which Child A has attended since 2005.

Records in Child A's file report that he is prescribed an atypical anti-psychotic drug licensed for young people of fifteen years and above, which is described as suitable for the treatment of schizophrenia, mania and bi-polar mania. He also takes sleeping medication on a nightly basis. The Occupational Therapy report at age four states that Child A has received six one to one sessions to work on his pencil grip and fine motor skills and is on a waiting list for a motor skills group in order to continue to develop his skills. According to his school, Child A has recently been diagnosed with Tourettes Syndrome on the basis of a facial tic he has

developed and his seemingly uncontrolled use of abusive language when angry. A report detailing the extent and implications of this latest difficulty is still to be received.

3.3 Present Educational Provision

Child A's teachers report that he has settled well into his new class since September 2007 and has been attending school regularly. However the scheduling of three psychotherapy sessions per week during school time does impinge on his opportunities to be fully included in lessons and extra-curricular activities.

My own observations of Child A in his school environment depicted a pupil who is enthusiastic about learning and keen to contribute to lessons. His class teacher reports that he has good general knowledge but quickly becomes defensive when he finds a task difficult, particularly if it involves writing. He engages and interacts with his classmates appropriately during lessons; however he is often involved in 'rough' play during unstructured break times.

Child A's teachers report that he understands the school rules and the sanction and reward systems, although he finds it difficult to accept responsibility when he does something wrong, often blaming members of his family for his 'bad' mood. Severe temper tantrums reportedly occur approximately once a week and can require physical intervention by the teachers in order to keep Child A and other children safe. Once these incidences are over Child A is able to be reconciled with the staff and shows remorse. His teachers report that he often seems to test their relationship with him by stating 'I'll kick and bite you and you won't like me'.

Currently school-based intervention is focussing on increasing the length of time Child A is able to concentrate on a task and developing his social skills through access to a social interaction group, high levels of adult support in small group and whole class activities and reinforcement of positive social skills during circle time.

4. Use of the Label ‘Attachment Disorder’

4.1 What is an Attachment Disorder?

Attachment Disorder is a term often used casually by professionals working with nursery and school-aged children, particularly in relation to those who are in the care of the local authority, fostered or adopted. There are currently two main areas of theory and practice relating to the diagnosis of attachment disorder.

The first is based on scientific research which underpins the inclusions of attachment disorder as a distinct disorder in DSM-III by the American Psychiatric Association in 1980. It is used by clinicians in the Child and Adolescent Mental Health Services and is most recently described in the DSM-IV (American Psychiatric Association, 1994) as Reactive Attachment Disorder (RAD). The second area is more controversial in the claims it makes relating to attachment theory and its use of attachment therapies, such as holding therapy, which have little or no evidence base (Chaffin et al, 2006).

Child A was given an attachment disorder diagnosis and the resulting treatment, provided by the Child and Adolescent Mental Health Services, was and continues to take the form of intensive psychotherapy. However reports in his file do not specifically state the evidence and

behaviours on which the diagnosis was based, nor do they identify which subtype of RAD he has. Even when a diagnosis is given there still remain questions concerning the criteria set out in DSM-IV and how accurately these reflect attachment theory. Borris, Zeanah, Larrieu, et al (1998) compared the reliability of differing criteria for attachment disorders using retrospective case reviews which were coded by four clinicians according to whether the child presented with an attachment disorder or not. They found that the DSM-IV criteria had only marginal interrater reliability in comparison to proposed alternative criterias. Zilberstein (2006) recognises that RAD is a relatively new disorder and diagnosis, which is not well researched and where conflicting ideas exist about its etiology and presentation, some of which are discussed below.

One criticism of the RAD is the extent to which it is congruent with attachment theory. Zeanah (1996) emphasises that attachment theory is a theory of development, not pathology and that there is no clear point at which normal variations of attachment become a disorder. In addition to this, psychopathology is often the result of a number of risk factors, of which a poor early attachment relationship may be one (Sroufe, 1997). However a disorder is better predicted by a number of risk factors than attachment classification alone. Carlson (1998) asserts that children with disorganised patterns of attachment may be at risk of developing RAD, but this does not mean they will. The impact of other important aspects of primary relationships, such as play, discipline and support for the development of self-regulation, are not considered in attachment theory, (Rutter, 1997 cited in Zilberstein, 2006). Therefore to determine which problems are a result of poor attachment specifically is difficult, especially as children are continuously developing (Sroufe, 1997).

Another contention with RAD is that the two subtypes of attachment disorder described in DSM-IV (inhibited and disinhibited) do not correspond with the three insecure attachment classifications from the theory (Zilberstein, 2006). Case studies of children with RAD describe behaviours associated with both disorganised attachment (Hinshaw-Fuselier, Boris, & Zeanah 1999) and behaviours associated with insecure attachment (Shin, Lee, Min et al, 1999). This criticism is further corroborated by extreme case studies of institutionalised children, such as the Romanian orphans, where the behaviours observed differ from the DSM-IV descriptors (APA, 1994) (O'Connor et al, 2003). The DSM-IV criteria (APA, 1994) have been further criticised because of their 'within child' focus rather than recognising the reciprocal nature of the attachment relationship (Zeanah, 1996). In addition to this it does not allow for different attachment relationships with different caregivers (Boris & Zeanah, 1999). Zilberstein (2006) suggests that the DSM-IV affords a singular, concrete criterion for RAD which does not allow for differing or evolving presentation of attachment behaviour as the infant moves into adolescence and then adulthood.

Some clinicians have broadened the DSM-IV (APA, 1994) criteria to include 'secure base distortions' which they consider a more accurate reflection of the clinical population and attachment theory (Zilberstein, 2006). Zeanah and Boris (2000, cited in Zilberstein, 2006) assert that when an attachment disorder is conceptualised in this way it can fall into three subtypes: disorders of non-attachment, disordered attachment and disrupted attachment disorder. The disorder of non-attachment corresponds most closely to the DSM-IV (APA, 1994) criteria where the child has no discriminating attachment. Disordered attachment is where the infant has an attachment figure but there is intense conflict in their relationship, resulting in the child trying to control the caregiver. Finally disrupted attachment disorder is

where an infant is grieving due to the sudden loss of their attachment figure through separation or death. In common with the DSM-IV criteria, this approach is limited in its application to older children and adolescents because of the lack of research with this age group. It is also yet to be tested and proven through research and casework (Zilberstein, 2006).

These concerns over the diagnosis of attachment disorders raise queries about how useful it is for the professionals working with Child A to give attention to his diagnosis of attachment disorder. Firstly there are no details in his file relating to the subtype of attachment disorder he may have and the term Reactive Attachment Disorder is not used at all. If this diagnosis has been given correctly and is the basis of the intensive psychotherapy Child A is receiving, then surely it is important for all involved to know the details of the disorder so they are able to support him in the most effective way. It could further be argued that the use of the term attachment disorder, despite its lack of specificity, promotes perceptions that ‘expert’ medical opinion has an authoritative and reliable basis which can not be challenged, and serves to keep knowledge, questions and concerns about the theory tightly within the ‘expert’ professional sphere. Knowing the limitations of the diagnosis and the alternative ways of conceptualising attachment difficulties may help Child A’s parents and teachers to increase their understanding and change their perceptions of his needs.

4.2 Comorbidity of Attachment Disorder with other Conditions

The American Psychiatric Association includes the presence of ‘inappropriate social interaction’ in their DSM-IV (1994) criteria for the diagnosis of Reactive Attachment Disorder. Attachment disorders have also been associated with delays in language and

difficulties in communication (Bowlby, 1969) and self-stimulating behaviours (Richter & Volkmar, 1994).

Similarly the DSM-IV (APA, 1994) diagnostic criteria for autism include qualitative impairment in social interaction and communication, and restricted, repetitive and stereotyped patterns of behaviour, which is why there can be difficulties in distinguishing the two disorders (Mukaddes et al, 2004). However DSM-IV (APA, 1994) does specify that there has to be a history of pathogenic care and the presumption that the social disturbances are the result of insufficient care, when diagnosing RAD. When discussing RAD Zilberstein (2006) asserts that,

‘clarifying core characteristics of this disorder and distinguishing them from co-morbid conditions are critical for improved diagnosis and treatment of children with attachment disorders.’ (p.55)

Research has shown that children with autism are able to form secure relationships with their primary caregiver, displaying proximity seeking behaviour when separated from their caregiver and directing more social behaviour towards them in comparison to a stranger (Buitelaar, 1995). However a meta-analytic review of autism and attachment carried out by Rutgers, Bakermans-Kranenburg, van IJzendoorn et al (2004) showed that children with autism were significantly less securely attached to their parents/caregivers than comparable matched children without autism. This difference between children with autism and those without becomes less obvious in samples where the autistic children have higher cognitive functioning and less severe symptoms of autism.

There are questions concerning the ecological validity of some of the attachment research involving children with autism where Ainsworth's (1978) Strange Situation Procedure is used. Rutgers et al (2007) argue that autistic children may find the new surroundings and departure of their primary caregiver without warning particularly distressing because of their sensitivity to sudden changes.

Child A was given diagnoses of attachment disorder and autism at the age of five years. It could be argued that because of the considerable overlap in the behaviours associated with autism and attachment disorder and the co-morbidity between them that these diagnoses were given prematurely.

During an observation of Child A he was seen to interact with his peers, using their names to attract their attention and talking with them in an appropriate way. His teachers report that he has made and sustained friendships with members of his class and that he gives eye-contact when they speak to him. This evidence could be interpreted as contradicting with a diagnosis of autism.

The diagnoses given to Child A are likely to remain with him throughout his education and into adulthood, affecting others' expectations of what he can achieve and causing them to interpret his behaviour within set boundaries. This raises questions about the need for professionals to allow infants time to develop before making a diagnosis, particularly where the case and behaviours are complex. However this would have implications for deployment of resources to educational settings, as extra funding, or the process by which it is allocated, often depends on or results in a diagnosis.

5. Critique of Attachment Theory

If the diagnosis and treatment of attachment disorder is based on attachment theory and the body of research that underpins it, then it is important to understand their limitations. Concerns have been raised about the stability of attachment classifications, the deterministic nature of attachment theory, its perceived ‘mother blaming’ and disregard for the reciprocal nature of the attachment relationship. Furthermore Ainsworth’s Strange Situation Procedure, on which the majority of attachment research is based, can be critiqued on the basis of its epistemological and ontological assumptions and methodology.

5.1 Stability of Attachment Classification

Bowlby (1969) and Ainsworth (1973, cited in Goldberg, 2000) both suggested that attachment develops in four stages, three that occur during infancy and the fourth in the preschool years. This, in combination with the fact that the Strange Situation Procedure was designed for use with children from 12-18 months, has resulted in most of the research using classifications from the strange situation to predict later competencies and outcomes. Such research has led to the implicit assumption that attachment classification does not change after the preschool years, leading to a difference between our belief that attachment is a lifelong construct and our actual knowledge of what happens to it beyond infancy (Goldberg, 2000).

Research suggests that over time both consistency and inconsistency can be shown in attachment classification depending on life circumstances (Thompson, 1998). Where there is change between infancy and adulthood in most cases the subjects had experienced some form

of major upheaval such as death of a parent, abuse or serious illness (Waters et al, 1995, cited in Bee & Boyd, 2007). Using the Adult Attachment Interview (George, Kaplan, & Main, 1985; Main, Kaplan, & Cassidy, 1985) Pearson, Cohn, Cowan et al (1994) found that between 40-70% of adults who were rated as secure fell into the 'earned secure' classification, suggesting that they had been characterised by insecure attachment patterns previously. Goldberg (2000) asserts that the study of stability and change of attachment style over the lifespan is an area that is now recognised as under-researched.

Crittenden (2000) argues that attachment theory can not be applied to describe human behaviour because it is a model based in infancy, limited by the immaturity of the infant organism and its lack of life experience. Through her Dynamic Maturational Model Crittenden (2000) suggests that experience can lead to both change and continuity in the pattern of attachment. In particular this model focuses on two periods of maturational shift, where neurological change takes place: the progression from infancy to pre-school age and from school age to adolescence. Crittenden asserts that three types of change can occur; change from one pattern of attachment to another, change in the choice of strategies used and change from simple to more complex sub-strategies within a dominant pattern. An example of this is the change in transparency of emotion in infants and in their ability to distort, falsify and omit information from their processing as they mature, hence developing new strategies for self-protection and new attachment patterns/ behaviour. Crittenden (2000) suggests that her model, which allows for a dynamic interaction of maturation can better account for developmental processes, the variation seen between child and adult attachment behaviour and human adaptation under a range of life conditions, and so emphasises the means by which attachment patterns may change as well as remain stable.

5.2 Deterministic Nature of Attachment Theory

The previously discussed assumption of the stability of attachment classification throughout the lifespan within professional practice has given attachment theory the reputation of ‘infant determinism’; that what happens in infancy has a power over later life (Kagan, 1998, cited in Goldberg, 2000). However attachment theory is not the only developmental paradigm that emphasises the importance of the early years and it does allow for change in attachment classification, although there remains a lack of research in this area (Goldberg, 2000).

Longitudinal research carried out by Chisholm, Carter, Ames et al (1995) and Chisholm (1998) compared the attachment status and development of three groups of children: Romanian orphans adopted before four months of age, Romanian orphans who had spent at least eight months in an orphanage before being adopted and a control group of Canadian children matched according to gender and age. Attachment was assessed using parents' responses to the 23 items with the highest and lowest loadings on the security scale of the Attachment Q-sort (Waters & Deane, 1985) 11 months into the adoption and when the majority of the children were four and a half years old. On the first assessment the orphanage group were rated as less secure in their attachments than those in the other groups and on the second assessment 58% of the control group and 67% of the early adopted children were rated as secure compared with 37% of the orphanage group. In addition to this a significantly higher proportion of the orphanage group compared with the other groups showed atypical forms of attachment. The attachment patterns of the orphanage group were shown not to be related to aspects of their time in the orphanage, such as length of stay, but rather to child and adoptive family characteristics. Insecurely attached children were more likely to have behaviour

problems and developmental delay in comparison with securely attached children and their parents reported more stress.

This research suggests that it is desirable for secure attachments to be formed early in infancy, although there are currently no agreed limits for this 'critical' or 'sensitive' period (Goldberg, 2000). Following research with children who were placed in foster care Dozier et al (1999) found that those fostered after 12 months of age were more likely to behave in a way that made normal and sensitive care difficult to give. These babies were more likely to act as if they did not want or need care, were difficult to sooth and their foster mothers were more likely to become frustrated with them. This suggests that children who have had a negative early attachment relationship are more likely to learn behaviours that make it challenging for them to form new secure attachments.

On the basis of the above research it could be argued that attachment theory is not deterministic because it recognises that secure attachments can be formed despite the absence of secure attachment bonds with primary care givers in the children's early years. There seem to be a number of factors influencing this, such as the time when new attachments are formed and the characteristics of the child and the family or caregiver they are forming an attachment with, which can be seen as compounding insecure attachment or as providing opportunities for the development of secure attachments. As Thompson (1999) asserted, outcomes predicted by insecure attachments seem to be more 'contingent and provisional' than they were originally thought to be.

It is important for Child A's parents and teachers to be aware of this debate and the mixed evidence underlying it. I believe attachment theory can be viewed as deterministic because of its main research bases which focus on outcomes for infants categorised as having insecure attachment behaviour, but also because of the way it influences expectations of a child. Knowing that being fostered or in care is not, in isolation indicative of insecure attachment, is important in preventing both professionals and adoptive/foster parents making assumptions about irrevocable social, emotional and behavioural outcomes for a child.

5.3 The Reciprocal Nature of the Attachment Relationship: Temperament and 'Mother Blaming'

Attachment theory has been challenged for continuing the tradition of 'blaming the mother' (Chess & Thomas, 1982). Goldberg (2000) argues that Bowlby himself used the terms 'mother' and 'primary caregiver' interchangeably, and that this practice is based on the fact that the majority of research has been carried out with mothers because they are overrepresented as primary caregivers. Therefore, in this regard, the research reflects the culture in which it is carried out, rather than making arbitrary assumptions about mothers' habitual position, and hence influence as primary caregivers and/or blaming mothers for their attachment relationship with their child and the developmental consequences resulting from this.

Related to this is the argument that if attachment is the product of a reciprocal relationship then both parties in that relationship must have an effect on it. Researchers have shown that intensity and /or impact of reactions in the Strange Situation Procedure differ, suggesting this may reflect variations in the intensity of attachment relationship. Kagan (1994, cited by Bee

& Boyd, 2007) suggests that some of these differences may be due to variations in the child's temperament. In turn Zeanah and Fox (2004) suggest that differences in temperament may be related to security of attachment. Research has shown that 'easy infants' defined by the Thomas and Chess (1977) system are more likely to be securely attached than babies who do not fall into this category (Vaughn, Stevenson-Hinde, Waters et al, 1992). However Van IJzendoorn, Goldberg, Kroonenberg et al (1992) suggest that this is only a correlation rather than a causal influence, as the majority of babies in all three temperament categories are securely attached.

It has been suggested that it is not temperament per se that influences attachment, but the interaction between the infant's temperament and the environment (Thomas & Chess, 1977). If the parents of an irritable baby are able to tolerate his/her moods, then his/her temperament per se. may not lead to the formation of an insecure attachment (Bee & Boyd, 2007). This approach to attachment theory could be seen as non-deterministic because it recognises another factor that impacts on the attachment relationship.

In the case of Child A and other children diagnosed with attachment disorders it may be helpful for the adopted or biological mother to know that factors within the child influence the attachment relationship also. This may act to remove some of the responsibility of their child's attachment classification from them and help them understand both their own and the child's role in the attachment relationship. If a mother is aware that a child who presents as having a difficult temperament can still form a secure bond with her, then she may respond to the child differently and be encouraged to persevere with the relationship.

6. Critique of the Strange Situation Procedure

Goldberg (2000) emphasises the extent to which attachment research is founded on the Strange Situation Procedure. It is the best known measure of attachment for infants and so has come to be viewed as a 'gold standard' against which many of the other measures of attachment for older children, such as the Attachment Q-sort (Waters and Deane, 1985) and the Pederson-Moran Home Assessment (Pederson and Moran, 1995, 1996), have been validated. Goldberg argues that there are two faults with this; it assumes that attachment patterns remain stable, which, as discussed previously may not be true, and it limits the measures used within attachment research,

‘There is an inherent danger in basing an entire theoretical edifice on any one assessment procedure.’ (p.243)

As the age of the research sample increases so do the number of methods available for assessing attachment. This results in opportunities for the triangulation of data through the use of multiple methods, and contingent opportunities both to test and strengthen the reliability of the theory.

6.1 Epistemological and Ontological Assumptions of the Strange Situation Procedure

Cohen, Manion and Morrison (2000) describe three different approaches to research, outlined in Table 3. Decisions concerning which approach to use are based on the researcher's views of the world and hence their ontological and epistemological assumptions. Burrell and Morgan (1979) suggest that ontological assumptions are concerned with the nature of social phenomena: whether social reality is external or created in the individual's mind, and explain

epistemological assumptions as relating to the nature and forms of knowledge, how it is gained and passed on to others. Hitchcock and Hughes (1995) state that ontological assumptions will give rise to epistemological assumptions, which will in turn influence methodological considerations, that will in their own turn inform choice of instrumentation and methods of data collection.

From the Strange Situation Procedure it can be asserted that Ainsworth et al (1978) have taken a traditional or Positivist approach to their research. There is nothing inside an infant or adult that can be identified and labelled as a secure or avoidant attachment. Within the Strange Situation Procedure behaviours are observed and classified as being markers for an attachment pattern. In turn these behaviour patterns are interpreted as reliably reflecting features from the complexly organised behavioural system operating in the natural environment (Goldberg, 2000). The Strange Situation Procedure does not allow for each attachment relationship to be personal and unique, nor does it seek to gain the mother's interpretation of the observed behaviours.

Table 3: Ontological and Epistemological Assumptions Underpinning Different Approaches to Research

Methodological Approach	Ontological Assumptions	Epistemological Assumptions
Scientific/positivist	<ul style="list-style-type: none"> -Reality is external to individuals -Reality consists of events that are orderly and lawful -Objects exist independently of the knower 	<ul style="list-style-type: none"> -Knowledge is 'hard', objective and tangible - It is possible to transfer the assumptions and methods of natural science to social science - Science separates facts from values

	(Burrell & Morgan, 1979)	and therefore is value free (Cohen et al, 2000)
Naturalistic/interpretative	<ul style="list-style-type: none"> - Reality is created in a person's own mind - There is no independent thing that constitutes meaning, just sets of meaning and classifications that people attach to words (Burrell & Morgan, 1979)	<ul style="list-style-type: none"> - Knowledge is based on personal experience, it is subjective and unique. (Burrell & Morgan, 1979)
Critical Theory	-Shares the same assumptions as interpretive approach (Cohen et al, 2000)	<ul style="list-style-type: none"> - Rejects objective knowledge - No neutral perspectives because everyone is socially located and the knowledge produced will be influenced by this. (Usher, 1996)

Through its assumptions it claims that relationships can be understood by observation and categorisation of behaviour, without the need to elicit an understanding of that behaviour from those involved in it. Rules can be applied to every infant- primary caregiver relationship in order to fit them into an attachment type and similar behaviour seen in two different relationships is considered to have the same meaning behind it. It also assumes that the researcher will be objective and not allow their values to influence the interpretation of the behaviour or information they collect.

6.2 Methodological Limitations of the Strange Situation Procedure

Critics of the Strange Situation Procedure, such as Chess & Thomas (1982) and Kagan (1994) question what it actually measures. Is it measuring the construct of attachment by reflecting the infant's experiences of the caregiver's response to their needs or is measuring the child's

temperament? Temperament theorists suggest that the Strange Situation Procedure elicits infant characteristics such as their vulnerability to distress, how they express it and how they manage it (Goldberg, 2000), and that these variables should not be considered independently of other variables such as the caregiver's approach to child care and how they interact with the developing infant. Evidence for and against this argument was discussed previously (see Section 5.3), however in relation to the method of the Strange Situation it is important to consider which factors, other than attachment experiences, may instigate the behaviours observed during the eight increasingly stressful episodes. This is highlighted by Rutgers, Bakermans-Kranenburg, van IJzendoorn et al (2007) who found that Autistic children were particularly distressed by the departure of their caregiver and the sudden changes of the experiment, suggesting that the Strange Situation Procedure may not measure attachment in certain clinical groups.

Another methodological limitation of the Strange Situation Procedure is that early reliability tests carried out by Ainsworth et al (1978) showed that the test could not be re-administered within a similar age range because infants remembered the previous experience and became extremely distressed. This itself raises significant questions about the ethical acceptability of the procedure. It is suggested that a 4-6 week gap should be left before administration, limiting assessment of the test-retest reliability of the procedure within a narrow age range. Furthermore the uneven distribution of the different attachment categories has led many researchers to group the insecure classifications together or to 'ignore' the smallest group, which is the resistant category. This limits the unique information that can be collected about each classification and Goldberg (2000) argues it can create 'good versus bad', over-

simplistic research findings, which do not reflect the complexity of attachment relationships and behaviours.

The failure to differentiate the insecure groups in research could be viewed as encouraging the assumption that infants who show any form of insecure attachment in the first year of life will share similar outcomes. This is unhelpful for children with an ‘attachment disorder’ such as Child A, because it deters others from focussing on individual differences, and on the strengths of a child, and risks serving to pathologise the group.

The body of research on the outcomes for infants with different attachment classifications, covering relationships within their family, achievement and social adjustment at school and beyond into adult life, and their own parenting skills, is likely to be influential on education professionals. If incompletely or uncritically understood, application of attachment theory may act to limit the school and teachers’ expectations of the child, affecting the way they work with her/him and ultimately the message the child receives about him/herself through this work.

7. Attachment Theory and Attachment Disorder: Implications for the Educational Provision Child A Receives

It is important to consider the positive contributions that attachment theory can offer in understanding the needs of children, and the role that Educational Psychologists can play in this. The apparently increasing awareness of attachment disorders, as evidenced by recent citations in government documents such as Care Matters: Time for Change (DfES, 2007),

could act to create opportunities for Educational Psychologists to share attachment theory with school staff as a framework through which to formulate and understand children's needs. Within this section this report discusses the two questions posed in section one and concludes by considering question three, the risks and benefits of being diagnosed with an attachment disorder for children within the education system.

7.1. How useful is the diagnosis of an Attachment Disorder in informing the support and provision that Child A is receiving in his educational setting?

Knowing that Child A has been diagnosed as having an attachment disorder provides a context within which his teachers can understand and interpret his behaviour, whilst research on how insecure attachment patterns may impact on learning, development and relationships could be used to inform teaching strategies and create a 'safe' classroom environment for him. Child A's school caters for children with varying levels of ability and need by having high adult to pupil ratios and by using small group or one to one work as their main method of delivering the curriculum. My own observations suggested that this environment is supportive and responsive to Child A's complex needs, but could draw further on the research and interventions developed around attachment theory which are discussed below.

Geddes (2003) focuses on the triangular relationship between the teacher, pupil and task, and the potential these relationships have for changing the child's Internal Working Model and increasing their resilience. By analysing cases from a child guidance archive she makes links between early relationships and the learning profile of children from each of the three insecure attachment classifications (see table 4) (Geddes, 1999, cited by Geddes, 2005). Geddes (2005) makes suggestions for teaching strategies and task management that will

prevent children from experiencing negative interactions in school which are similar to those they had with their primary caregiver.

Table 4: The Learning Profiles of Children with Insecure Attachment Classifications

Attachment Classification	Learning Profile
Resistant /ambivalent	<ul style="list-style-type: none"> • Focus on teacher rather than task • Clingy and dependent • Poor achievers • Good verbal skills used for attention seeking
Avoidant/ anxious	<ul style="list-style-type: none"> • Does not expect teacher to help • Avoids closeness with adults • Engages in task only if it can be completed independently • Poor language, avoids expressing feelings
Disorganised/ disorientated	<ul style="list-style-type: none"> • Rejects adults, does not trust them • Unpredictable outburst of aggression • Avoids situations where they may feel threatened or helpless • Unable to understand or express the strong feelings they experience • Hyperactivity • Absence of empathy towards others

In response to pupils with resistant patterns of behaviour Geddes (2003) suggests that the teacher needs to recognise the meaning of the behaviour and provide an achievable task for the child, modelling the steps of the task and working along side the pupil, rather than merging with them, will encourage the child to focus and achieve independently. Where the child is avoidant the teacher can use the task as a safe opportunity for the child to interact with a non-rejecting adult and so increase their resilience. This is most effective if the child has a

choice in the task, it is achievable and the teacher respects their need to manage proximity between themselves and other people (Geddes, 2005). Where pupils have a disorganised/disorientated classification Geddes (2005) suggests that they need to experience emotional containment within school. This can be created through the availability of a safe, quiet place, predictable routines throughout the school day and predictable responses from the adults teaching them. Here the task should be differentiated appropriately so it is 'safe' for the pupil, often simple mechanical or rhythmic activities will allow the child to feel contained whilst achieving.

Geddes' work (1999, 2003, 2005 & 2006) can be critiqued on several different levels, including her lack of clarity in the methodology used and the subjective nature of her findings. In her published papers (2003, 2005) which precede her book (2006) Geddes draws on findings from her unpublished thesis (1999) but does not describe her methodology in replicable detail, stating that she examined a sample of cases from child guidance archive files and,

'links [were] made between early relationships and subsequent response to the teacher and how children responded to the challenges of the learning task.' (Geddes, 2003, p.79)

Then from her experience of working as an educational therapist she gives illustrative examples of these patterns of behaviour in the classroom, in the written and artwork of her 'cases'. Geddes (2003, 2005 & 2006) asserts that she brings a psychoanalytic approach to her work but fails to provide any evidence that she has verified the links she makes by asking the child what their behaviour, writing or artwork means. Geddes adopts a positivist epistemology to her research, evidenced by the choice of observation as her main method (see table 3);

however aspects of her research contrast with her epistemology, for example she does not give enough detail about her methods to allow them to be repeated by others. In addition to this she does not make it clear how the attachment classification of pupils she used in her original work was determined, nor does she consider threats to the reliability or validity of information abstracted from Child Guidance files.

Golding (2006), a Clinical Psychologist specialising in looked after and adopted children, describes how schools can be a cause of stress for children with attachment difficulties because of the learning, relationship and environmental demands on them, as well as the assumptions schools generally make about children which may not be relevant to all individuals. Golding goes on to argue that school requires that the child becomes increasingly independent and organised, manages relationships with their peers, whilst tolerating separation from their attachment figure. The conventions and culture of school expect children to be able to regulate stressful experiences and relationships, whilst having a capacity for emotional literacy and cognitive abilities which are age appropriate. Golding believes that by being more aware of just how challenging the school environment can be to children with attachment difficulties, teachers' understanding of behaviour and of how to make school less threatening for such children will be enhanced.

Golding (2006) asserts that behaviour management programmes which may be suggested as an intervention for pupils with the types of demanding behaviour that frequently characterise children with attachment difficulties, assume that they are able to regulate their impulses and have relationships with their teacher within which pleasing their teacher would be motivating and desirable. A fundamental supposition of many of these programmes is that the child will

be able to learn from observing cause and effect, a cognitive skill which may not be developed in some children with attachment difficulties (Cairns & Stanway, 2004). Golding (2006) would offer as an interpretation of the purpose of Child A's challenge to his teachers (see section 3.7), that they will not like him after one of his behaviour tantrums, as maintaining his negative self-concept, something which he may find more rewarding than pleasing staff or receiving praise.

Golding (2006) suggests that schools can support pupils such as Child A by creating a context of safety, where there is routine, structure and help for pupils in seeking support from adults. She uses the acronym of PACE to describe how relationships can be developed through playfulness, acceptance, curiosity and empathy. Golding highlights the need to work at the level of the child's developmental, rather than chronological age, modelling fun to develop the capacity of enjoyment, using social stories to develop social awareness and discussion to develop reflectivity, for example. Most importantly she emphasises the need to not make assumptions about the cognitive and emotional skills of the child, but rather to focus on creating opportunities to develop these skills.

7.2 What are the Implications of Attachment Theory and Research on the Role of the Educational Psychologists in the Case of Child A?

One role for the Educational Psychologist working within Child A's school would be to support his teacher to understand aspects of the school environment and expectations, discussed in section 7.1, which may be challenging for him. It is also important for his teacher to understand the significance of her own relationship with him, and how this may be qualitatively similar to that between the child and primary-caregiver (Pianta & Steinberg,

1992). Howes (1999) researched attachment relationships in the context of multiple caregivers and identified three criteria for developing relationships beyond the family environment: provision of physical and emotional care, a consistent presence in one's life and an emotional investment in the individual. Educational Psychologists can support teachers in exploring how children may be affected by their relationship and the tasks that they set (see section 7.1).

Kennedy and Kennedy (2004) highlight the fact that there is little literature on school-based, attachment focussed interventions; most are clinic-based and designed for use with parent-child pairs. They emphasise Bowlby's (1969) assertion that learning is most efficient when the environment can be explored from a secure base and identify the teacher's role as important in creating this essential condition for learning;

‘through the opportunity for emotional and physical proximity the student-teacher relationship may provide for exploration from a secure base and a safe haven under stress.’ (p.251)

However in order to provide a secure base for the child the teacher must recognise their expectations of the interactions they will have with their pupils, how this is evident in their own behaviour, and that it is the product of their own Internal Working Model of attachment (Kennedy & Kennedy, 2004). Leiberman (1992) suggests that for interventions to be successful they require teachers to understand their own Internal Working Models and those of the students, whilst recognising that the student's behaviours reflect their experiences and relationship history, in addition to other dimensions of children's personality, and ecological dynamics of the classroom.

8. Conclusions

Where theories are applied to real life practice it is important for them to be used in a fully informed way, with consideration given to the entirety of the research that underlies such theoretical positions. Attachment theory provides a paradigm through which to understand early development and has initiated a mass of research focussed on the relationship between the child and primary caregiver. This research has added to knowledge of individual differences but has also lead to their labelling and categorisation, and ultimately, the diagnosis of disorders based on these differences. It could be argued that the benefits of identifying medical conditions and psychiatric disturbances such as increasing understanding of a person's behaviour, needs and provision of appropriate treatment justify this categorical approach. Child A's diagnosis has resulted in him receiving medical treatment and psychotherapy; however the author would question the extent to which it has informed his provision in school and enriched workers' understanding of his behaviour.

In the case of Child A and others in the education system, the 'loose' and naive references to an attachment disorder by professionals who have only a slender background in psychology can act to undermine any benefits the theory has the potential to bring. The criticisms of attachment theory, its focus on stability of classifications and deterministic prediction of outcomes, are the aspects of the theory that are best known and so can act to limit the expectations adults hold for children who are believed to have attachment difficulties.

A lack of transparency and detail in medical reports as to the evidence Child A's diagnosis is based on acts to compound misconceptions about attachment difficulties. Similarly the fact that no reference is made to the subtype of Reactive Attachment Disorder means that the diversity and specificity in presentation of attachment behaviour is neglected and choice of appropriate interventions remains ill-informed. Child A is an example of the breadth of impact that labelling of disorders can have on a pupil, currently and throughout their education into adulthood.

If attachment theory and research is presented accurately to schools and professionals working with children then the benefits are potentially many, allowing, for example, the identification of at-risk groups (both parents and children) and for preventative actions to be taken in response to this. Arguably the most valuable aspect of attachment theory is the meaning it gives to a child's behaviour. It removes the focus from 'within- child' causes to early relationships and the ecological and systemic factors which may impact on them. It also emphasises the importance of the teacher's relationship with the child. The author believes Child A would benefit if the staff in his school were supported in developing their understanding of the complexity of factors which influence attachment and how they can create a safe context in which 'A' can develop his social, cognitive and emotional skills. Most significantly adults working with Child A should be helped to identify his unique attributes which may mean he is an exception to the outcomes predicted by attachment research.

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CHAPTER THREE

THE CHALLENGES OF RUNNING A PARENTING PROGRAMME IN AN INNER CITY SCHOOL: A REVIEW OF THE EVIDENCE OF WHAT MAKES A PARENTING PROGRAMME SUCCESSFUL WITH REFERENCE TO A CASE STUDY IN A WEST MIDLANDS PRIMARY SCHOOL

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SCHOOL

Abstract

The effectiveness of parent management training or behavioural parent training as an intervention for children with conduct disorder is well established within literature. However with the increasing government focus on ‘good enough’ parenting and extended Local Authority powers to request ‘parenting orders’ which compel parents to attend such courses, questions about the capacity of parenting interventions to improve behavioural outcomes for all children are being raised. This report considers the current political climate in which parenting courses are taking place and the theoretical basis of these interventions. A case study of a group Triple P Parenting Programme carried out in an inner-city, economically deprived area is outlined and research evidence on the practical, content and client-based factors which influence the outcomes of parenting interventions are discussed with reference to this particular example. Conclusions are drawn concerning the changes which could be made in order to increase the effectiveness of a parenting course within a similar catchment area to the case study and the need for further research into what aspect of parenting interventions are best suited to the needs of hard to reach groups is emphasised.

THE CHALLENGES OF RUNNING A PARENTING PROGRAMME IN AN INNER CITY SCHOOL: A REVIEW OF THE EVIDENCE OF WHAT MAKES A PARENTING PROGRAMME SUCCESSFUL WITH REFERENCE TO A CASE STUDY IN A WEST MIDLAND PRIMARY SCHOOL.

1. Introduction

Behaviour problems in the form of anti-social behaviours and conduct disorders (sometimes labelled externalising behaviour problems) in children and young people constitute one of the major challenges currently faced by the government in England. Frequent newspaper headlines and the identification of behaviour as a priority by schools and Children's Services all over the country has resulted in government initiatives and legislation such as Every Child Matters (DfES, 2003), leading to the establishment of Sure Start Children Centres, and the Social Exclusion Action Plan (The Social Exclusion Task Force, 2006). One particular focus of government policy has been the role of parenting in the prevention of anti-social behaviour. In 2000 this led to the implementation of parenting orders, issued by magistrates, requiring that parents of young offenders and frequent school-refusers receive parenting education and support. This was extended in 2003 by the Anti-Social Behaviour Act (Home Office, 2003) which permitted Local Authorities (LAs) to apply for parenting orders in response to pupils' poor behaviour and attendance at school.

Research in Britain has suggested that 7.4% of boys and 3.2% of girls aged 5 to 15 years are conduct disordered (Meltzer et al, 2000), with this figure increasing up to 20% in disadvantaged areas (Attride-Stirling et al, 2000a). It is estimated that children with anti-social behaviour problems at the age of ten are likely to cost the state three times more than their peers in fees relating to crime, special education, health, social security and foster or residential care (Scott et al, 2001). These children often grow up to be 'costly' adults, with 40% of those diagnosed with conduct disorder in childhood developing 'serious psychosocial problems' as adults, including crime, drug misuse and violent behaviour (Coid, 2003). Although the effects and cost of behavioural problems during childhood are well documented, it has been estimated that fewer than 1 in 5 British children with significant needs in this area receive help from specialist services (Attride-Stirling et al, 2000b).

Difficult life and family circumstances such as poverty, poor housing, single or young parenthood, substance misuse and mental health problems have been identified as increasing the risk of conduct disorder; however it is through the mediating effects on quality of parenting that the impact of such circumstances is believed to be realised (Patterson & Forgatch, 1995). Whilst some children are more challenging to parent than others, it is parenting behaviours, including inconsistent discipline, poor supervision and harsh punishment, which are believed to influence the development and maintenance of behavioural problems (Hutchings & Bywater, 2007). It is not surprising therefore that parenting programmes or parent management training/behavioural parent training (PMT/ BPT) have been proven, through over 30 years of research, to be an effective intervention for reversing 'coercive family processes' and challenging child behaviour (Hoghugh, 1998; Desforges and Abouchaar, 2003; Nixon, 2002) and as crime prevention measures (Ghate & Ramella, 2002).

From their review of the literature on parenting programmes Desforges and Abouchaar (2003) found that 'at home good parenting' had a significant influence on a child's achievement and adjustment, even when all other factors that effect achievement were controlled for, suggesting that parenting programmes may also improve educational outcomes.

Miller and Sambell (2002) assert that policy-makers', practitioners' and researchers' focus on the importance of parenting has resulted in it being construed as a,

'public activity open to the scrutiny of parents and professionals alike.' p. 32,

initiating a debate around what 'adequate' or 'good enough' parenting is. The term 'good enough' was coined by Winnicott (1964) who believed that parents need to provide a 'facilitating environment' which is sensitive to the child's needs, but by using this phrase recognised that 'perfect parenting' did not exist. The concept of 'adequate' parenting is also subject to the influence of political, professional and personal agendas which may be operating in society or families at any one time. The occurrence of 18 knife-related deaths of young people in London between January and July 2008 (Guardian.co.uk, 2008) and the ensuing press headlines, have lead to current debates concerning 'adequate' parenting being dominated by questions about how gang culture and violence can be prevented.

Golding (2000) asserts that the concept of adequate parenting is difficult to define because of the number of variables which impact on the child-parent relationship. However she suggests that clinically this judgement is based on the effects parenting has on the behaviour displayed by the child and on the treatment the child receives from the parent. Parenting programmes

assume a deficit in parenting skills and on this premise the goals of such interventions are to produce the following changes:

- A reduction in aggressive and non-compliant behaviours and an increase in pro-social behaviours displayed by the child.
- A reduction in the use of physical methods of discipline used by parents and an increase in appropriate parenting skills.
- An increase in positive interactions in the parent- child relationship. (Golding, 2000)

Within this report, as with much of the research into parenting interventions, I use the term ‘parents’ to include both mothers and fathers, although the literature indicates that men are less likely to participate in parenting programmes (Redmond et al, 2002), as was reflected in the case study (see Appendix 1). The majority of the literature in this domain, unless specifically focussing on mothers or fathers, describes the gender distribution within the sample and then reports outcomes of the group as a whole. This may be misleading because there is evidence to suggest that men and women respond differently to programmes, depending on the amount of life stresses they are experiencing (Reuter et al, 1999), and that men may need activities that are specifically designed to attract them, and members of staff dedicated to keeping them engaged (Lloyd et al, 2003).

2. The Theoretical Basis of Parenting Programmes

Most parent management or behavioural training programmes are social-learning-based interventions which focus on improving parenting skills in order to treat the behavioural

problems of the child (Golding, 2000) and are based on the assumptions presented in Figure 1. These assumptions are supported by behavioural research showing the relationship between parenting practice and child behaviours (Patterson, 1986) and by experimental research which demonstrates that changes in parenting practice lead to changes in child behaviour (Kazdin, 1997). Pioneering research in this area was carried out by Skinner (1953) who analysed the 'contingencies' involved in parent-child interactions (Taylor & Biglan, 1998). His theoretical account was further researched and developed by others, such as, Patterson and colleagues (1975, 1982) and Hanf (1970, cited by Webster-Stratton & Taylor, 2001).

Golding (2000) states that in order fully to understand the assumptions that underpin behavioural parent training it is important to know the models on which it is based. These models draw on diverse theories which explain the behavioural, emotional and cognitive development of the child in relation to the family, including attachment theory (Bowlby, 1973), social learning theory (Bandura, 1977), social construction theory (Vygotsky, 1960) and information processing models (Beck, 1976; Brewin, 1987). The scope of this report does not allow each of these theories to be considered; however Golding (2000) suggests that attachment theory and social learning theory are the most relevant to understanding how parenting affects the adjustment of the child, and so these are outlined below.

Attachment theory focuses on the attachment between the parent and child and how this can be influenced by the quality of the relationship the parent had with their own parents. A child may become insecurely attached to their parent if the parent finds it difficult to empathise or respond sensitively and consistently to their needs. Ainsworth (1989) demonstrated the effect this may have on the child's behaviour using the Strange Situation Procedure. However

attachment theory is difficult to apply practically to interventions aimed at changing behaviour because notions such as empathy or sensitivity are difficult both to define, and to judge whether either is absent or present (Golding, 2000).

Figure 1: Fundamental Assumptions Underlying Behavioural Parenting Programmes

- Human behaviour is the product of the effects of reinforcement and punishment experienced through daily exchanges with the environment.
- Parenting behaviour is related to child behaviour.
- Antisocial behaviour is learned from and sustained by positive and negative reinforcement children receive from those who interact with them, mainly parents.
- Parenting interventions seek to change child behaviour by positively reinforcing children's pro-social behaviours and consistently punishing or ignoring unwanted behaviours.
- Changes in parenting behaviour can be maintained by the associated improvement in child behaviour and adjustment.
- Behaviour is best understood and changed within a behaviourist model

(Adapted from Dumas, 1989 & Golding, 2000)

Social learning theory focuses on the family as a system within which the child learns patterns of behaviour through exposure to maladaptive or adaptive family interactions (Grusec, 1992). The child forms concepts about behaviour through observation, and these concepts are modified or strengthened as behavioural patterns by modelling, shaping and both direct and vicarious reinforcement. Patterson (1982) uses social learning theory to explain the development and maintenance of behavioural difficulties within a child. Parents can improve

children's behaviour through positive reinforcement using mechanisms such as praise, attention and rewards; however they are also able to reinforce negative behaviours inadvertently through giving attention or by using methods to placate or distract which the child may find rewarding (Taylor & Biglan, 1998). Patterson (1982) also recognised that child-parent interactions can be coercive. This occurs where the aversive behaviour of the child is stopped or reduced in frequency by the aversive behaviour of a parent. Although this may prove to be a short term solution, unless the parent's aversive response is maintained, the child's aversive behaviour is likely to be increased through the operation of negative reinforcement contingencies.

One of the first Behavioural Parent Training (BPT) programmes to be developed and evaluated was the work of Hanf (1969) which used didactic instruction, role-play and modelling to help parents learn how to change their own behaviour in order to see a change in their child's behaviour (Skkerketich & Dumas, 1996). Subsequently, the instruction and two core techniques of differential reinforcement and time-out used in BPT have been developed into 'comprehensive, manualised interventions' to modify undesirable behaviour in children (Skkerketich & Dumas, 1996), such as Incredible Years (Webster-Stratton, 2001) and Triple P Positive Parenting Programme (Sanders, 1999, 2001, Sander et al, 2001).

In the following section this report will introduce the case study of a Triple P Positive Parenting Programme which took place within a West Midlands Local Authority. It will briefly outline the circumstances and setting in which the course took place and introduce this specific parenting programme, its principles for delivery and learning, and the theory on which it is based.

3. Case Study of a Parenting Programme

3.1 Context of the Case Study

This case study Triple P parenting course was carried out in an inner city primary school in January 2008. The school is located in a relatively disadvantaged and diverse community with pupils from a range of minority ethnic communities. The Acorn description of this neighbourhood is an area of low family incomes, few houses with mortgages and a very low number of people educated to degree level. Long term unemployment is high and there are equivalent numbers of single-parent families and traditional two-parent families (Acorn, 2008).

The parenting course was suggested and agreed upon during a planning meeting at the beginning of the school year. It was advocated by the School's visiting Educational Psychologist (EP) of a year in response to the high number of behavioural concerns that had been raised in previous meetings and based upon knowledge of the local area. The school's senior leadership team were keen to support the proposed parenting intervention fully and provided the school annex/ community room as a meeting place. The course was advertised in the school newsletter and the local community nurse was informed about it. Initially eight parents responded to the advert, and pre-course interviews were arranged, and completed in six cases, during which initial assessments of parenting strategies and style were to be carried out. Appendix 1 provides a descriptive overview of the participants, which will be referred to throughout this report. The parenting programme was run by the school's visiting EP, who had been trained as a Triple P facilitator, myself, during my first term in post as a Trainee

Educational Psychologist and a number of other Triple P-trained EPs from the Local Authority Educational Psychology Service, who contributed to individual sessions.

3.2 Triple P- Positive Parenting Programme

The Triple P Positive Parenting Programme (Sanders 1999, 2001; Sanders et al., 2001) is described by its creators as

‘a multilevel, preventively oriented, parenting and family support strategy’ (Sanders et al, 2003, p156).

Developed in the University of Queensland, Australia it aims to prevent ‘severe behavioural, emotional and developmental problems’ in preadolescent children from birth to 16 years by improving the ‘knowledge, skills and confidence’ of parents (Sanders, 1999, p.72). Its claims also extend beyond improvement in parenting and child behaviour to promoting environments for children that are safe, nurturing and engaging, in addition to improving language and intellectual competencies (Sanders et al, 2003). The programmes have five levels on a tiered continuum of strength (see Appendix 2), recognising that families will have differing levels of need which should to be responded to with interventions of appropriate intensity, presentation mode and duration. By having this multi-level approach Triple P claims to,

‘maximize efficiency, contain costs, avoid waste and over-servicing and ensure the programme has wide reach in the community.’ (Sander et al, 2003, p.156)

Sanders et al (2007) describe Triple P as having a public health perspective, where the intervention is based on the ‘minimally sufficient conditions’ that are needed to change a

child's risk of or trajectory towards developing conduct problems and the consequences that can go with this (discussed in Section 1).

Providing an appropriate service to meet parents' needs means they are more likely to attend and complete the course because of its relevance. An additional advantage claimed for the tiered approach is that it can be delivered by differentially qualified professionals, allowing for better utilisation of the existing workforce in the domain of parenting, and for practitioners to determine the scope of the intervention they are able to provide depending on the needs of their clients and the funding available to them (Sanders, 1999). The programme is also flexible in the delivery modalities it uses, with options of individual, group, telephone-assisted and self-directed programmes.

Sanders et al (2003) describe Triple P as a 'behavioural family intervention' which draws on a number of theoretical models outlined in Figure 2. These are similar to those identified by Golding (2000) (discussed in Section 2) but differ with the inclusion of the 'population health perspective'. This perspective considers how human development is influenced by the ecological context within which it takes place; for example, a population health perspective assumes that antisocial behaviour in children will not be reduced unless the community context for parenting changes (Biglan, 1995).

Triple P purports to adopt this method through Level One of its tiered continuum, a 'universal parent information strategy' which provides interested parents with parenting information using a media and promotional campaign comprising accessible methods of conveying information such as fact sheets and videos (Sanders, 1999). Sanders et al, (2003) assert that

Level One of their parenting programme has the effect of normalising parent experiences, including attending a parenting course, and whilst doing this gains support from community stake-holder such as schools.

Figure 2: Theoretical Models on Which Triple P Positive Parenting Programme is Based

- social learning models
- effective behavioural techniques evidenced by family behaviour therapy and applied behaviour analysis
- developmental research on the influence of parent-child interaction on language and intellectual development
- research on developmental psychopathology focussing on risk and protective factors linked to adverse life outcomes
- social information processing models which emphasise the importance of parental expectations, beliefs and attributions
- a population health perspective to family intervention (Sanders et al, 2003)

3.3 Group Triple P Parenting Programme

Group Triple P is positioned at Level Four of the 5-tiered intervention and is aimed at families with children who have ‘detectable’ behavioural problems but who do not meet the criteria to be diagnosed with a behaviour disorder (Sanders, 1999). Group Triple P can be used with parents of children who are already identified as requiring an intervention or can be used more broadly in order to distinguish which families are in need of support for example,

‘A group version of the program may be offered universally in low-income areas, with the goal of identifying and engaging parents of children with severe disruptive and aggressive behavior.’ (Sanders, 1999, p.81).

Group Triple P comprises eight sessions for a group of ideally between 10-12 parents. There are four two-hour sessions which include 'active skills training' in areas such as encouraging desirable behaviours and teaching new skills, managing misbehaviour, problem solving and planning for high-risk situations (see Appendix 3 for course content). During these sessions parents have opportunities to learn through observation, discussion, modelling and role-play, as well as being given homework tasks in order to consolidate new skills. Following the group sessions, three 15-30 minute telephone sessions provide additional support for parents, with a final group meeting on the eighth week to celebrate changes in behaviour and discuss future goals and access to support on completion of the course. The program uses a variety of media and resources such as parent workbook and DVD clips (Turner, Markie-Dadds & Sanders, 2000).

The Triple P Positive Parenting Programme encourages the evaluation of each intervention, and by setting up Triple P local area networks and a website through which outcome results are collated, aspires to add to the evidence base for its effectiveness. The facilitator's manual provides a number of different child and parent questionnaire measures which can be used, but recommends a minimum pre and post-intervention assessment to include The Strengths and Difficulties Questionnaire (Goodman, 2000); Parenting Scale (Arnold et al, 1993); Parent Problem Checklist (Sanders & Dadds, 1993) and Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995).

Further details of the case study will be discussed within Section 4, as key factors in the planning and delivery of parenting programmes are considered individually with reference to existing research findings on successful parenting interventions. I will also reflect on the

practical challenges of using the Triple P materials, the pre and post intervention assessments, and programme resources in the context of the case study.

4. Key Factors in Planning and Delivering a Parenting Programme

4.1 Venue / Setting of Parenting Programme

In their research carried out within 134 Local Authorities (LAs) in England, Hallam et al (2007) report that of the 125 parenting programme providers who responded to a question concerning the venue used for courses, 71% reported that programmes were held in community settings, 10% in schools and 19% in both types of location. The majority of programmes located in schools were in primary schools and generally programme providers reported that schools were supportive and that appropriate facilities were made available, although lack of space was sometimes a problem. The research report states that the advantages of school-based parenting programmes include improving home-school relations and encouraging consistency in approaches towards children's behaviour in home and school settings, aiding the monitoring and evaluation of the effectiveness of the programme and having comparatively low drop-out rates compared with programmes held in other community settings, which was predicted to be because parents already had transport to the school. These findings are supported by parents (Rogers et al, 2008) who felt they were able to communicate more effectively and less defensively with teachers about their child's behaviour after attending a school-based parenting course. Head teachers also reported that pupils enjoyed their parents' increased involvement and presence at school.

In the current case study the Triple P parenting course was held in a community room located on a school site. The course was advertised in the school newsletter to all parents, but was also made available to parents of children who did not attend the school, although none of the participants fell into this latter category. The advantages of choosing a venue on the school site included limiting the costs for running the course, easy access to technical support and resources, and parents' familiarity with a location to which they had daily access. The building itself was also spacious and comfortable, with kitchen facilities, which the literature recognises as important in helping parents to feel at ease and to relate to the programme facilitators (Webster-Stratton and Herbert, 1993). The course facilitators predicted that participants' easy access to the venue and the fact that sessions were timed to start immediately after children were dropped off at school, would encourage regular attendance; however this was not the case. Attendance at the course varied over the five sessions which required the participant's presence at the venue, with only two of the six parents present at the final two sessions.

Where parenting courses are held in schools, whether they are facilitated by school staff or external professionals, it is important to consider the constructs and attitudes parents hold about school and their involvement with it. Although the scope of this report does not allow for detailed examination of the literature concerning influences on parent participation in schools, there is evidence that educators' middle-class perceptions of appropriate behaviour and communication methods (Christopher, 1996) may act to alienate parents from lower socio-economic backgrounds, reinforcing perceived or real feelings of powerlessness (Michel, 1997), and evoking their own negative experiences of education (Rich, 1987). In contrast to the above suggestion of socioeconomic class differences being influential in parent

participation, Wood and Baker (1999) found that parents from different ‘class’ backgrounds reported similar preferences for and barriers against school-based parenting education programmes; however “low socio-economic status” parents reported that they were less likely actually to attend such events (see Section 4.6 for further discussion). The researchers state that their findings demonstrate that need to differentiate between espoused parental interest and actual participation in school events, suggesting that it is often pragmatic and economic factors, rather than interest, that are influential in parents’ non-attendance.

In the school where the case study parenting course was carried out many of the parents or members of their families grew up in the local area and some attended the school as children themselves, which could either positively or negatively influence their willingness to participate in the course depending on their experiences of school (DfES, 2004a). A further factor which is likely to affect parents’ perceptions of involvement in a school-based course is their child’s behaviour in school as well as at home: if a child’s behaviour in school has been problematic, leading to frequent negative feedback from school staff, this may cause the parent to become defensive. Such parents may not want their child’s school to know they are attending a parenting course and may therefore be unlikely to choose a course organised by or located in school premises (Rogers et al, 2008).

4.2 Length, Duration and Target Age Range of Parenting Programme

Hallam et al in their DfES (2004a) research project (also reported in Hallam et al, 2007 & Rogers et al, 2008) found that parenting programmes across the 134 participating LAs in England differed in a number of ways relating to their structure and content, including length of the course, the number of courses running in each LA, age of children and parents each

course catered for, the focus and aims of the course and the mode of delivery used. Hallam et al (DfES, 2004a) state that LAs and providers report parenting courses as taking place over 1-14 sessions, with the most commonly reported length being 8 sessions over 8 weeks. However Wood and Baker (1999) in their research carried out in the USA with 395 parents of 'elementary' school children from low income backgrounds found that the majority of parents preferred a short number of sessions, (4 instead of 6-10), or single sessions on individual topics. However the number of sessions that parents are willing to attend and the number of sessions needed for the course to be effective may differ. Kazdin (1997) asserts that time-limited programmes of less than 10 hours are less effective than longer programmes of 50-60 hours. In the current case study although the Triple P Parenting Programme took place over 8 sessions, with an estimated time of approximately 12 hours, three of these sessions were carried out by telephone and so had the advantage of not requiring the parent to travel to the venue or make practical arrangements for child care or provision of meals.

Hallam et al (2004) report that a range of parenting programmes is available which cater for different groups of parents, for example teenage parents or single parents. A number of programmes target children of different ages, such as pre-schoolers, 5-11 year olds and teenagers. Parent management training typically focuses on children aged 3- 8 years (Golding, 2000); however there is evidence that it is most effective with pre-school children (Webster-Stratton, 1997) when negative behaviours and patterns of interaction are less ingrained. In contrast to this Serketich and Dumas (1996) carried out research using data from 26 studies of Behavioural Parent Training that meet criteria for inclusion in their meta-analysis. Effect sizes of the parent training were calculated for five outcomes measures, four of which were child-based and one of which was parent-based, with most studies reporting a combination of child

outcome measures including parental report, behavioural observation and/or teacher report. Serketich and Dumas found that overall effect size was associated with one contextual variable: that families with older children (primary school aged) benefited the most from the parent training. However as the oldest sample included had a mean age of 10.1 years, conclusions can not be drawn about the effectiveness of such programmes with adolescents.

Woolpert et al (2006) reviewed the evidence in support of the effectiveness of parent training programmes as an intervention for children with Conduct Disorder and found an improvement in the behaviour of two thirds of children under the age of 10 years whose parents participated; however the effectiveness with adolescents was reported to be limited. Golding (2000) suggests that debates concerning the optimum age of children whose parent attends child management training are far from resolved, and that severity and complexity of need may be more salient in explaining differential treatment outcomes.

The Triple P Positive Parenting Programme claims to be relevant to parents of children from birth to age 16 years, and although the current case study was carried out with parents of primary school children, discussions and examples within sessions were not limited to the target children of this age only; often younger or older siblings were also discussed (see Appendix 1 for age of children). Hallam et al (2004) found that of the 37 LAs who responded to their question about providing training for parents of children of differing ages, although there was provision for different age groups, within each LA this was not sufficient to meet the needs of parents of children of all ages.

4.3 Format and Components of Parenting Programme

The Triple P Parenting Programme and many of the other behavioural management training programmes have ‘enhanced’ versions with aims that extend beyond the social learning model and the limited goals of improving parenting skills (Long, 1996), and focus on family interactions and feelings of self-efficacy within parents. This is in response to findings which suggest that it is ‘marital, psychopathological, attitudinal, socioeconomic and community contact variables’ (Sanders & Christensen, 1985, p. 102) which determine whether families achieve successful or unsuccessful outcomes from participation in parent training programmes (Griest & Wells, 1983). Enhanced Triple P contains elements such as home visits, stress-coping and mood management strategies in addition to partner support skills (see Appendix 2). Golding (2000) asserts that such approaches allow programmes to be tailored to meet the needs of individual families, resulting in better attendance and fewer drop-outs, as well as improvements in parenting skills that extend beyond behaviour management to problem-solving and communication skills.

Sanders et al (2007) carried out a three year comparison study where participants were randomly allocated to four groups; standard, self-directed and enhanced Triple P interventions or waiting list, in order to compare the effectiveness of the different variations of the programmes. 305 families of children aged three years old were recruited to take part in the research and a range of measures, including parent self-reports such as the Beck Depression Inventory (BDI: Beck et al, 1979) and The Parenting Scale (PS; Arnold et al, 1993), and observations of mother-child behaviour were taken immediately after completing the intervention and at one year (Sander et al, 2000) and three years after this (Sanders et al, 2007). Post-intervention the enhanced condition showed the most consistent short-term

improvements over the measurement domains relating to child behaviour, and across measures of parenting practice and competence, followed by the standard, self-directed and then the waiting list conditions. However at the one year follow-up, in which 162 families participated, all three intervention conditions were associated with similar levels of improvement on child and parent outcome measures (Sanders et al, 2000) and at the 3 year follow-up, in which 139 families were available to take part, the measures again showed comparable maintenance of treatment gains across all three variants of the parenting programme (Sanders et al, 2007).

Although the enhanced version of Triple P was more effective immediately after the intervention, Sanders et al (2007) recognise that the comparable effectiveness over time of all three variants of the Triple P Parenting Programme shows that,

‘The prediction that greater changes in child disruptive behaviour would occur when an intervention concurrently targets not only parenting practices, but also marital communication and parental mood variables was not confirmed.’ (p. 995)

Similar results were found in three other studies using Triple P, where the benefits of adjunctive procedures have been shown not to be significant (Foster et al. 2003; Ireland et al. 2003; Plant and Sanders 2007). In contrast to the Triple P research Griest et al (1982) had carried out a similar study comparing a standard individually administered parent training programme with a programme which also targeted personal and marital adjustment and the mother’s extra-familial relationships. Post-treatment results here showed that both groups made significant progress, with a decrease in poor child behaviour, increased maternal rewards and child compliance; however only the ‘enhanced’ group maintained these effects at the two month follow-up. Due to the design of the study it is impossible to determine which

aspects of the advanced course may have been responsible for the improved maintenance of changes.

Standard Triple P does not contain adjunctive interventions such as partner-support skills or stress management; however it does include planned activities training (PAT) which was first described by Sanders and Dadds in 1982. This approach involves identifying settings where parents find managing their child's behaviour particularly difficult, and then parents are taught a broad range of stimulus control and organisational skills, such as advanced planning of an outing and establishing ground rules (Sanders & Christensen, 1985). Sanders and colleagues have carried out a number of studies comparing standard child management training with programmes which include PAT, and have had mixed results. Sanders and Dadds (1982) found a significant effect of including PAT in parenting programmes, whilst Sanders and Christensen (1985) found its effect was not superior to that produced when using child management training alone. However these studies differed in the settings in which observational measures took place, with the former including community settings, whilst the latter was based within the family home. This suggests that PAT may produce greater effects in community settings or that it may be most useful where parents are unable to generalise the skills they have learnt through parent management training, but does not have added value where the training has been successful (Sanders & Christensen, 1985).

The Triple P case study course was the standard group version and so did not contain any adjunctive procedures; however its content did extend beyond child management training and included a focus on parents looking after themselves, for example having time away from caring for their children occasionally (see Appendix 3 for course content). When problems

relating to this or other non-child behaviour topics were raised by parents, the group and facilitators were able to share solutions or provide information that may help. This seemed to be an appropriate and relevant response to the group's needs, rather than including adjunctive procedures, because it provided opportunities to discuss individual problems, ensuring relevance, and also allowed the course to remain contained within the 5 scheduled two-hour sessions. The case study did include one session on PAT in which parents had showed interest from the beginning of the course because many of the behavioural problems they shared occurred in community settings, such as supermarkets, doctors' surgeries or in home situations, such as bath or meal times, where PAT would be appropriate. Feedback from parents indicated that they found it helpful to think about specific situations in advance and to plan the strategies they could use to manage their child's behaviour.

4.4 Model of Delivery: 'Group vs. Individual'

Amongst the range of parent management training courses presently used there are commonly two main models of delivery: these are group and individual programmes. In some parent management training such as Triple P, individual family/parent formats are used with enhanced versions of the programmes where the needs of the family are more challenging and complex. However some parenting programmes are always delivered to individual families; for example, Parent-Child Interaction Therapy (PCIT) involves the facilitator coaching parents as they interact with their child over an average of 12 to 14 weeks (Thomas & Zimmer-Gembeck, 2007). Webster-Stratton and Hancock (1998) assert that group programmes have been shown to be as effective as individual ones, and have the advantage of being more cost effective in comparison, whilst providing peer support for parents, reducing isolation and so increasing engagement with the programme.

However Golding (2000) suggests that group programmes may mask the needs of individual families, and parents may be deterred from attending such groups because of fears that they will be criticised or rejected. Where families have complex needs and chaotic, disorganised lives, attending a weekly course may prove challenging. In such cases individual home-based programmes allow the flexible administration of the course and increase chances of successful completion, whilst providing the opportunity for parents with low levels of confidence to rebuild their skills and self-efficacy. Hallam et al (2006) in their case studies of parenting courses taking place in five LAs, found that group programmes often focussed on building support groups or partnerships between parents that would continue once the course had finished. Miller and Sambell (2003) used in-depth interviews to explore parents' 'beliefs, expectations and experiences' of parenting courses and found that parents valued being listened to in an informal setting,

‘It’s important to see that other people are going through the same thing. It’s a big comfort to know that you’re not on your own.’ (p.37)

The case study Triple P programme was delivered in a group format, with the number of participants recommended to be between 8-12 people. Sanders (1999) recognises that although delivery of the program in a group setting may mean parents receive less individual attention, benefits include support, friendship, constructive feedback and opportunities for parents to normalize experiences through peer interactions. Some of the parents in the case study knew each other because their children were at the same school, but none of them were ‘close’ friends. Throughout the course there was evidence of relationships growing, with parents sharing openly during partner work or discovering that their children were friends or

attended the same sports club. Before the course started there were some concerns raised by the Head Teacher about ‘feuding’ families in the local area and long-lasting rifts which may negatively affect the group’s relationships if parents from these families wished to attend. Fortunately this challenge did not occur; however, making sure parents felt at ease and encouraging them to function as a group depended greatly on the facilitator’s skills, especially as some members of the group struggled during partner discussions because of cultural and language differences (see Section 4.7 for further discussion about facilitator qualities).

4.5 Selection / Recruitment of Participants

There are two distinct methods by which parents may be recruited to or commit to attend a parenting programme, either voluntarily or through a parenting order, both of which have implications for parents’ commitment to the course and their level of engagement during sessions. As stated in Section 1 of this report, parenting orders (introduced in 1998 and implemented in 2000) can be issued by magistrates to parents of persistent school refusers and young offenders, requiring them to attend parent education programmes (Rogers et al, 2008). However the Anti-Social Behaviour Act (Home Office, 2003) introduced new powers allowing LAs to apply for parenting orders to help address a child’s poor behaviour in school following a permanent exclusion or two fixed term exclusions within 12 months. Specifically parenting orders may be used where parents are refusing voluntarily to cooperate with the LA or school and ‘parenting’ is viewed as playing a part in the child or young person’s challenging behaviour.

It could be argued that there is a continuum between voluntarily attending a parenting course and being required by law to do so, through which participants may find themselves selected.

Professionals such as the school nurse or a teacher could recommend a course (Rogers et al, 2008) or as in the present case study, it could be suggested by a GP, Head Teacher or another senior member of school staff. Hallam et al (2007) report that typically when parenting courses are hosted by schools attendance is voluntary and all parents are invited to attend the course. This was the initial approach adopted in the current case study; however after a poor response to an advert in the school newsletter the Head Teacher suggested that school staff raise the parenting programme as a positive intervention when discussing children's behaviour with their parents. Where attendance at a course is suggested as a targeted intervention, there are risks that parents are alienated by the differential power relationships with professionals demonstrated in such signposting or advice and may feel pressurised into attending, leading ultimately to resentment. This is apparent in a quote taken from a questionnaire in research by Rogers et al (2008) concerning parents' expectations and experiences of parenting programmes;

‘When I first went there I went with anger in me actually thinking I don’t know why I’m doing this. I don’t need to do this. I did it to keep the school happy, show I am willing to do things to help my son.’ (p.18)

In their review of practice relating to parenting programmes in 134 LAs, Hallam et al (2007) found that very few parenting orders had been used to direct parents to courses at the time of data collection and that few LAs (six providers of the 36, who responded to the question), offered separate programmes for parents attending voluntarily or compulsorily. The questionnaire responses suggest that parents who attend parenting programmes compulsorily demonstrate more negative attitudes initially towards the course; however it was recommended that these could be overcome if parents were provided with an opportunity to vent their frustration and anger before commencing the course, and with a skilled facilitator

who is able to keep them engaged. Where courses were established in schools Hallam et al (2007) report that often parents asked to attend them; however schools expressed that these were not always the parents who would benefit most from the intervention, and generally persuading parents to attend courses was viewed as problematic.

Difficulty in reaching parents who need intervention the most is documented throughout parenting literature (Golding 2000), and although there is not the scope to cover this within the current report it is important to recognise that this dilemma raises questions about the use of expensive resources, such as the time of professionals, to run parenting courses when those attending such courses may not be the parents who benefit the most from it.

In the current case study none of the parents were attending under a court order; however the course had been recommended to some by the Head Teacher, and one parent attended because of this, even though she did not feel that her children had any behavioural problems (see Appendix 4 for summary of reasons for attendance at the course). Similarly another parent attended when, having approached her GP with concerns that her child had ADHD, he recommended that she try a parenting course before he would consider prescribing medication for her son or referring him for further investigations. Where the course had been suggested to parents, rather than their enquiring about it independently, in some cases these parents committed initially to the programme but then failed to attend pre-course interviews. However examination of factors influencing attendance extends beyond the methods by which parents were recruited for the course, as is demonstrated in the current case study through the drop-out of those who attended voluntarily.

4.6 Participant Profile: Cultural, Educational and Socio-Economic Background

Wood and Baker (1999) argue that commercially available parenting programmes, often used by schools hosting such courses, may not be responsive to or respectful of individual parents' needs and cultures. Researchers within this domain assert that 'generic' parenting programmes are designed for popular American, English, or in the case of Triple P, Australian culture, which is heavily influenced by white, middle-class values and presents 'Anglo' parenting attitudes and techniques (Kumpfer et al, 2002; Wood & Baker, 1999). The a lack of culturally specific parenting interventions has been attributed to the increasingly multi-cultural society in which we live, where people from many different ethnic and cultural background live, work and are educated together. In addition to this, generic programmes deemed to be acceptable to all families are likely to be more widely marketable and therefore more successful in uptake at least than their more tightly targeted competitors (Kumpfer et al, 2002). It may also be more cost efficient in terms of professional's time and resources to run parenting programmes that accommodate heterogeneous group composition, rather than limiting participants by specifying their culture or ethnicity as a pre-requisite for enrolling on a course.

Within this section of the report the influence of socio-economic status and cultural and ethnic background of participants in parenting interventions will be considered independently, and then in relation to how they may interact to influence access to and outcomes resulting from parenting programmes.

One of the risk factors predisposing families to unsuccessful outcomes following attendance on a parenting programme is low socio-economic status and poverty (Webster –Stratton &

Hancock, 1998; Webster-Stratton & Herbert, 1994). Research has shown that social class and/or socio-economic capital interacts with parenting practices to the extent that substantial differences are seen in parents with disparate economic status and educational levels (Hoff-Ginsburg & Tardiff 1995). Parents of higher socio-economic or educational status have been shown to value self-direction in their children, whilst parents from lower socio-economic or educational backgrounds more typically value their child conforming to authority (Baker & Wood, 1999). In addition to this, research into the reasons for early drop-out from parenting courses has repeatedly found that these parents have higher background levels of socio-economic disadvantage and life stress (Kazdin and Wassell, 1999; Webster-Stratton, 1992) (see discussion in Section 4.1). It is unclear if this is due to programme content being ill-matched to the needs of low socio-economic status parents or to practical restrictions and challenges, such as the time of the day the course is held, transportation or arranging child care.

Researchers studying parent participation in school events such as parenting courses have suggested three theories to explain why involvement of parents varies according to socioeconomic background. The culture of poverty theory asserts that “lower-class” and working-class cultures have different values and social organisation, resulting in such families not valuing education as highly as middle-class families (Deutsch 1967). Other theorists suggest that unequal levels of parent participation are due to the schools’ institutional discrimination, where middle-class families are made to feel more welcomed and valued (Lightfoot, 1978). The third theory is based on Bourdieu’s concept of cultural capital (1977; Bourdieu and Passeron, 1977) which suggests that schools disadvantage lower-class parents and children by using

‘particular linguistic structures, authority patterns, and types of curricula’ (Lareau, 1987 p.74),

with which middle class children are already familiar, and which facilitate both their adjustment to school and their academic achievement. All three of these theories emphasise the importance of the school’s relationship with its parents if it is going to host or facilitate a parenting programme, and in fact could be used persuasively to argue for such courses to be held in neutral venues with recruitment occurring through community organisations, rather than schools. Further research is needed to determine if social class differences in attendance at parenting courses are apparent to a similar extent in community run programmes, and whether these are subject to cultural bias to the same extent as those held in schools.

When considering research findings relating to social class differences it is important to take into account how participants’ socio-economic status was determined and how this may impact on the validity and reliability of the research. Some studies use parent’s education levels to allocate participants to socio-economic status categories (Flaughter, 2006) whilst others use vocational categories or annual income (Wood & Baker, 1999). All three methods have disadvantages, such as failing to consider the demands of being a single-parent family or having a large family on life-style, and the presumption that highly paid jobs are linked with educational levels and therefore social class. It is important to recognise that reliability and validity of conclusions ‘social class’ group may be limited because of the way in which participants were allocated to groups and the fact that the results may be specific to the location in which the study was carried out.

All of the parents who attended the case study parenting course were from poor socioeconomic backgrounds, none worked, and the majority of their partners did not either (see Appendix 1). This could be one of the factors contributing to the low initial take-up of the course and the poor attendance throughout (see Appendix 5 for attendance record). When these problems were discussed with the school staff it was apparent that the school frequently struggled with parental attendance at most events.

Critics of universal parenting programmes argue that not only are they biased against families of low socioeconomic status; they are also less accessible to ethnic minority families (Kumpfer et al, 2002). Recruitment to generic parenting courses has a response rate of 33% when advertised in schools (Weinberger et al, 1990); however this drops to 10% amongst ethnic minority families (Biglan & Metzler, 1999). In their American study, Wood and Baker (1999) found that African-Americans are more likely to show interest in parenting events than Caucasian parents, but are less likely to attend them. Kumpfer et al (2002) assert that often attempts to make parenting programmes more culturally relevant have resulted in surface or structural changes, such as hiring ethnically matched facilitators, or modifying media resources. Kumpfer et al in their 2002 study reviewed research which compared a generic version of the Strengthening Families Programme (SFP) with culturally adapted versions with parents from a variety of ethnic backgrounds, such as African Americans, Asian/Pacific Islanders, Hispanics and American Indians. Cultural adaptations included translation into home languages, increasing or decreasing the number of sessions, holding sessions in churches, addressing basic living needs and using culturally relevant media resources and example stories. Kumpfer et al (2002) concluded that cultural adaptations may,

‘substantially improve engagement and acceptability leading to better recruitment and retention of ethnic families, but only slightly improve outcomes.’ (p.245)

One explanation for these results is that changing programmes compromises the fidelity of the principles being taught, while reducing the number of sessions limits the opportunities to practise parenting strategies. It is also important to consider the often significant correlation between ethnicity and religious values, (although this can not be assumed), and how religious beliefs will also impact parenting practice. Where there are differences in both cultural and religious backgrounds there may be further challenges to accessing parenting groups, such as cultural norms concerning parental roles and acceptable child behaviours which may require more substantive changes to programmes content and delivery.

The Triple P parenting materials used in the current case study were developed in Australia and so reflect the ethnic diversity relevant to that country, with Caucasian, Aboriginal and Asian families appearing in the DVD clips. Although Sanders (2000) recognises that it is a matter of ethics to ensure that culturally mainstream interventions do not impact negatively on parents’ or children’s own cultural values or language, the Triple P materials provide little guidance on how to prevent this happening. Participants in the case study course were from a range of cultural and ethnic backgrounds, including African, Asian and Caucasian, with religious beliefs including Muslim, Christian and Hindu. None of the parents expressed any cultural problems with the parenting techniques which were presented; however some subtle differences were apparent during discussions about ‘play’ and behavioural expectations. Interestingly the two parents who attended regularly and completed the course were from different cultural backgrounds; one was White-British and the other a Sudanese Muslim.

Some changes were made to the content of the Triple P Parenting Programme used in the case study. However these were in the form of altering or shortening exercises, rather than eliminating or adjusting key elements of the theory. The changes made were based on knowledge of the parents who would be attending the course, and were a result of information collected at initial interviews. The Group Triple P Parenting Programme comes with scripts which we felt were inaccessible to our parents, and so altered to make the language simpler. No specific changes were made in relation to parents' ethnicities or religion; however discussions were developed around differences in parenting beliefs that were expressed, and we felt it was important not to over emphasise this, because as Forehand and Kotchik (2002) assert focussing on differences between groups can lead to unhelpful stereotyping.

4.7 Facilitator Profile: Personal Qualities and Professional Qualifications

Webster-Stratton and Herbert (1993) in their review of videotaped transcriptions of over 100 hours of group parent training programmes carried out in America claim that it is necessary for programme facilitators to be familiar with the content of video tapes and activities, but this is not sufficient for success because it fills only 20% of a group or individual session; the rest of the time is facilitator-led discussion and activity. On this basis they conclude that the second requirement for positive outcomes is a facilitator with 'a high degree of clinical skill' (p.409). The authors emphasise the salience of adopting a collaborative model where the facilitator works with parents through a supportive, reciprocal, non-blaming relationship, where parents set the goals for change and are given responsibility for bringing these about. Webster-Stratton and Herbert (1993) suggest that such a model of interaction increases parents' self-efficacy and motivation, prevents attrition and results in both the "therapist" and parents being stakeholders in the outcomes of the programme. The contrasting approach to

this is one where the therapist takes an 'expert' role which involves telling the parents what they should do in order to fix a deficit in their parenting skills. Such a hierarchical approach, the authors claim, can lead to reduced commitment, feelings of being de-skilled and ultimate resentment.

Webster-Stratton and Herbert (1993) stress the salience of the setting in which the course takes place, the pre-programme interviews, and the initial meeting where each parent's pre-existing constructs about such an intervention can be gently challenged and the facilitator can demonstrate a collaborative communication style and an accepting attitude to the participants. Through the qualitative analysis of their videotaped data the authors identified six process roles that needed to be fulfilled in order for the therapist or facilitator to manage the programme in a collaborative way. These are, building relationships, empowering parents, teaching, interpreting, leading and challenging and prophesizing/predicting futures problems with children's behaviour (Webster-Stratton & Herbert, 1993). Sanders and Dadds (1993) accentuate the importance of a collaborative process which leads to an agreement between the parents and the facilitator about the nature of the problem, a shared understanding of the causal factors in the problem and ultimately an acceptance of the relationship between the parent's behaviour and that of their child. Interestingly Miller and Sambell (2003) found that parents still had a 'dispensing model' view of parenting education and support, and expected expert knowledge to help them understand their child's behaviour and manage it. Taylor and Biglan (1998) summarise the findings of the above research as highlighting,

'the importance of clinical skills in the process of behavioural family interventions....' which are '..highly individualized and require many subtle and sophisticated skills for working with people.' (p.46)

Hallam et al (2004) found that where staff who ran parenting programmes were already working with children and parents, they tended to be professionals such as Educational Psychologists, Education Welfare Officers and Educational Social Workers. Many other group leaders came from a range of backgrounds where they had experience of working with families or children, such as teachers or health visitors. However where parents were recruited as facilitators having attended a course themselves, they often did not possess prior transferable training or professional experience. In the survey 85% of programme providers reported that all staff were trained in the model used in their course, whilst 26% indicated that their staff had a training qualification. There is a lack of studies that focus on the effects of the facilitator's 'levels' of training on the outcomes of parenting courses. However a recent study of parenting support by Moran and Gbate (2005) (including parenting programmes and formal support sources, such as social services) concluded that

‘generally, programmes of proven efficacy tend to use professionally trained workers and paraprofessionals rather than volunteers.’ (p333)

The Triple P parenting course recognises the need for facilitators to be trained in order ‘effectively (to) deliver empirically-based interventions’ (Sanders et al, 2003. p.166) and has developed a nationally co-ordinated system of training and accreditation, as well as a support network to maintain the quality of the programme. The Educational Psychologist with whom I ran the case study course was fully accredited as a Triple P facilitator and her knowledge and familiarity with the content and processes of the programme allowed both of us to focus on developing a collaborative model of working with the parents. Delivering the course with another colleague also meant that our practice could be supervised and we were able to reflect on the group dynamics, how to develop relationships and our own practice after each session.

Interestingly of the two course evaluations we received, both parents rated ‘discussion with facilitators’ as ‘most useful’; however it would be important to obtain views from those who dropped out of the course before drawing conclusions about the extent to which facilitator factors influenced attendance.

5. Discussion

5.1 Limitations of the Research

When considering the research on what makes parenting programmes effective it is important to understand the ways in which different studies have determined the success of the courses they are evaluating and to reflect on the identity of the researchers and how this may influence their findings. Thomas and Zimmer-Gembeck (2007) in their comparison of two different parenting courses assert that few previous reviews have systematically compared parenting courses which adhere to different methodologies, such as family-focussed interventions versus child-focussed interventions, and this has lead to largely undifferentiated evidence on the efficacy of such interventions, which broadly encompasses all behavioural parent training. Nixon (2002), in his literature review of parenting interventions that specifically target pre-schoolers, summarises the continuing limitations of research in this domain, chief amongst which he includes a lack of properly controlled randomised studies with adequate follow-up in order to determine if there is maintenance of treatment gains.

Amongst the research reviewed for this professional practice report I found that few of the studies reported in the literature included follow-up measures of change in child and parent

behaviour beyond a year after the intervention, with the exception of Sanders et al (2007) who carried out a three year follow-up.

Studies in this domain rarely provide enough details on the participants for cultural, educational and ethnic factors to be taken into account when considering the effectiveness of a parenting intervention, factors which should be of significance in the light of Webster-Stratton and Hancock's (1998) assertion that low social class is a risk factor to the success of behaviour parent training. Evaluations of parenting courses often vary in the measures used to determine successful outcomes. Some parenting programmes, such as Triple P, use several questionnaire measures filled in by the parent, whilst others include observation of child and/or parent behaviour/interactions carried out by a researcher, and teacher report. This makes drawing conclusions about the effectiveness of parenting programmes difficult because the size of the effect and even the judgement as to whether there has been a change in child behaviour may vary depending on the measures used or the person who filled it in. This is apparent in Nixon's (2007) meta-analysis of studies using Triple P and PCIT, where mothers reported moderate improvements after taking part in the self-directed Triple P, fathers reported large improvements, whilst clinical observations of the children's behaviour found no significant effects.

Another factor to consider when evaluating the success of a parenting intervention is the role of the facilitator, their competency and the extent to which they maintained the implementation fidelity of the programme. Hutchings and Bywater (2007) assert that in order to retain fidelity it is necessary to have access to the course materials and staff who are fully trained to use them. Some researchers suggest that not only should integrity of use of

treatment manuals be reported, but also the competency of the trainer (Nixon, 2007), accentuating the arguments put forward in Section 4.7 of this report concerning the importance of the facilitator's skills. In addition to this, many of the evaluations of commonly used parenting programmes discussed within this report, and hence the evidence base on which they are promoted, are carried out by the professionals who created or designed the programmes. When carrying out a literature search for this report using the British Education Index and Psychovid search engines I found that much of the published research evaluating Sanders and colleagues, Triple P parenting course and Webster-Stratton and colleagues' Incredible Years parenting course, were written by the programme creators, which highlights the importance of examining the measures used, how results are reported and possible factors which may have influenced the outcomes of the programme.

The literature reviewed in the current report provides mixed evidence on what makes a parenting course successful. The DfES (2004b) research report 'What works in parenting support' identifies five groups of factors that 'influence effective implementation' (p.96); practical, relational, strategic, structural and cultural/contextual. Research evidence relating to all of the five areas has been presented in this report, and discussed in relation to the case study parenting course. When reflecting on the case study, which aspects were successful and which may have impacted negatively on attendance or the parents' learning, it is important to emphasise that such reflections are subjective in their nature, as quantitative measures of the effectiveness of the course are unavailable. Although pre-intervention assessments were carried out with five members of the group, post-intervention measures could not be completed due to the drop in the number of group members at the end of the course. This attrition prevented qualitative measures of change in parents' perceptions of child behaviour

and parenting skills being taken. However two parents (of the original six) who attended the final session did fill in informal questionnaire evaluations and feedback was collected during telephone sessions.

6. Conclusions

If I were to co-facilitate a parenting course in a similar catchment area to the case study again I would consider trying to work more closely with other agencies in order to provide contacts and support to address wider problems in the lives of parents. I would also use recruitment strategies that did not involve local schools, and which reached a larger number of parents in order to increase the probability of a fully subscribed programme. It is important to evaluate the time demands of the course on the professionals facilitating it against its effectiveness, in terms of the number of parents who attend and those whose parenting skills are improved by doing so. If attrition rates are likely to be high in areas with multiple risk factors, such as where the cases study was based, it could be argued that Educational Psychologists should not be facilitating parenting courses, but rather using this time to deliver services to schools.

I think it would be beneficial to use incentives, such as vouchers and to have a pre-course event where parents' concerns and questions could be addressed, whilst the importance of regular attendance is emphasised. Within the case study catchment area, I think it would be important to use a neutral venue which is not attached to a school, but is able to offer additional facilities such as a crèche. I would also consider providing catch-up sessions and home visits for parents who found it difficult to attend on a regular basis.

It is easy to identify adjustments that can be made to an intervention in order to improve attendance and ultimately outcomes for parents; however the practical challenges and time demands involved in setting up such a parenting programme in 'real-life' could make it untenable or unjustifiable in terms of the cost of professional's time. Moran and Gbate (2005) assert that there is still a lot of 'patchiness' in knowledge relating to what works in parenting interventions, particularly in relation to the 'hard to reach' groups, who are most in need of support. They assert that researchers are partly responsible for this incomplete knowledge because their evaluations lack rigor and are fail to include difficult to reach groups, such as father and the children themselves. In addition to this bias against publishing studies with inconclusive or negative results (Stoiber & Kratochwill, 2000), means that the field is limited to only learning from successes. More research is needed as to what interventions work for different types of parents, and how these can be realistically provided, especially in the light of the governments focus on parenting, and requirements on children's services to justify the work they do in terms of effectiveness and costs.

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Appendix 1

Triple P Model of Parenting and Family Support (taken from Sanders, 1999)

Level of intervention	Target population	Intervention methods	Program materials	Possible target behaviors
Universal Triple P	All parents interested in information about promoting their child's development.	Anticipatory well-child care involving the provision of brief information on how to solve developmental and minor behavior problems. May involve self-directed resources, brief consultation, group presentations and mass media strategies	<i>Positive Parenting</i> booklet <i>Positive Parenting</i> tip sheet series <i>Families</i> video series <i>Every Parent Triple P Program Guide</i>	Common everyday behavior difficulties
Selective Triple P	Parents with a specific concern about their child's behavior or development.	Provision of specific advice for a discrete child problem behavior. May be self-directed or involve telephone or face to-face clinician contact or group sessions	Level 1 materials <i>Primary Care Triple P Practitioner's Manual</i> Developmental wall chart Consultation flip chart	Bedtime routine difficulties Temper tantrums Meal time behavior problems, Toilet training
Primary Care Triple P	Parents with specific concerns about their child's behavior or development that require active skills training.	Brief therapy program (1 to 4 clinic sessions) combining advice, rehearsal and self-evaluation to teach parents to manage a discrete child problem behavior	Level 1 and 2 materials	As for Level 2 Persistent eating problems Pain management
Standard Triple P	Parents of children with more severe behavior problems. Parents wanting intensive training in positive parenting skills.	Intensive program focusing on parent-child interaction and the application of parenting skills to a broad range of target behaviors. Includes generalization enhancement strategies. May be self-directed or involve telephone or face-to-face clinician contact or group sessions	Level 1 to 3 materials <i>Every Parent's Self-Help Workbook</i> <i>Standard Triple P Practitioner's Manual and Every Parent's Family Workbook</i> <i>Group Triple P Facilitator's Manual and Every Parent's Group Workbook</i>	General behavior management Concerns Aggressive behavior Oppositional defiant disorder Conduct disorder Learning difficulties
Enhanced Triple P	Parents of children with concurrent child behavior problems and family dysfunction	Intensive program with modules including home visits to enhance parenting skills, mood management strategies, and stress-coping skills, and partner support skills	Levels 1 to 4 materials <i>Enhanced Triple P Practitioner's Manual and Every Parent's Supplementary Workbook</i>	Persistent conduct Problems, Concurrent child behavior problems and parent problems. Child maltreatment

Appendix 2

Triple P Model of Parenting and Family Support (taken from Sanders, 1999)

Level of intervention	Target population	Intervention methods	Program materials	Possible target behaviors
Universal Triple P	All parents interested in information about promoting their child's development.	Anticipatory well-child care involving the provision of brief information on how to solve developmental and minor behavior problems. May involve self-directed resources, brief consultation, group presentations and mass media strategies	<i>Positive Parenting</i> booklet <i>Positive Parenting</i> tip sheet series <i>Families</i> video series <i>Every Parent Triple P Program Guide</i>	Common everyday behavior difficulties
Selective Triple P	Parents with a specific concern about their child's behavior or development.	Provision of specific advice for a discrete child problem behavior. May be self-directed or involve telephone or face to-face clinician contact or group sessions	Level 1 materials <i>Primary Care Triple P Practitioner's Manual</i> Developmental wall chart Consultation flip chart	Bedtime routine difficulties Temper tantrums Meal time behavior problems, Toilet training
Primary Care Triple P	Parents with specific concerns about their child's behavior or development that require active skills training.	Brief therapy program (1 to 4 clinic sessions) combining advice, rehearsal and self-evaluation to teach parents to manage a discrete child problem behavior	Level 1 and 2 materials	As for Level 2 Persistent eating problems Pain management
Standard Triple P	Parents of children with more severe behavior problems. Parents wanting intensive training in positive parenting skills.	Intensive program focusing on parent-child interaction and the application of parenting skills to a broad range of target behaviors. Includes generalization enhancement strategies. May be self-directed or involve telephone or face-to-face clinician contact or group sessions	Level 1 to 3 materials <i>Every Parent's Self-Help Workbook</i> <i>Standard Triple P Practitioner's Manual</i> and <i>Every Parent's Family Workbook</i> <i>Group Triple P Facilitator's Manual</i> and <i>Every Parent's Group Workbook</i>	General behavior management Concerns Aggressive behavior Oppositional defiant disorder Conduct disorder Learning difficulties
Enhanced Triple P	Parents of children with concurrent child behavior problems and family dysfunction	Intensive program with modules including home visits to enhance parenting skills, mood management strategies, and stress-coping skills, and partner support skills	Levels 1 to 4 materials <i>Enhanced Triple P Practitioner's Manual</i> and <i>Every Parent's Supplementary Workbook</i>	Persistent conduct Problems, Concurrent child behavior problems and parent problems. Child maltreatment

Appendix 3

Triple P: Overview of Session Content

Session number	Content	Duration
1- positive parenting	Working as a group What is positive parenting? Goals for change Keeping track of children's behaviour	120 mins
2- promoting children's development	Developing positive relationships with children Encouraging desirable behaviour Teaching new skills and behaviours	120 mins
3- managing misbehaviour	Managing misbehaviours Developing parenting routines Behaviour charts	120 mins
4- planning ahead	Family survival tips High risk situations Planned activities routines Preparing for telephone sessions	120 mins
5- implementing parenting routines 1	Preparing for the session Update on progress Other issues	15-30 mins
6- implementing parenting routines 2	Preparing for the session Update on progress Other issues	15-30 mins
7- implementing parenting routines 3	Preparing for the session Update on progress Other issues	15-30 mins
8- programme close	Phasing out the programme Progress review Maintenance of change Problems solving for the future Future goals Final assessment	120 mins

Taken from Sanders et al (2001)

Appendix 4

Parental Concerns/ Reasons for Attending Parenting Course & Reasons for Non-Attendance

Parent	Reasons for volunteered attendance (identified through pre-course interviews/ session discussions)	Reasons for targeted attendance (identified by school staff, school nurse)	Reasons for non-attendance (identified by school staff and parents)
A	Oldest son had temper tantrums		Moved house and children moved school 2 weeks into course
B	GP suggested course when he was consulted about oldest son's lively 'hyperactive' behaviour		Improvement in son's behaviour?
C	General behaviour of oldest son		
D	Distress, anxiety and anger displayed by oldest son		Unknown
E		Occasionally challenging behaviour of son	
F	Challenging behaviour of sons	Social services involvement	Unknown

Appendix 5

Parenting Course Attendance Record

Sessions completed									
Parent	Pre-course interview	1	2	3	4	Telephone sessions			8
						5	6	7	
A	√	√	√						
B	√		√	√					
C	√		√	√			√		√
D	√		√						
E	√	√	√	√	√	√			√
F		√		√	√	√			

CHAPTER FOUR

THE CHALLENGES OF WORKING WITHIN SCHOOL SYSTEMS:

APPLICATIONS OF SYSTEMS THEORY TO A SECONDARY

SCHOOL BEHAVIOURAL CASE STUDY, IN ORDER TO

UNDERSTAND WHY THE OPPORTUNITY TO WORK AT A

SYSTEMIC LEVEL WITHIN THE SCHOOL DID NOT OCCUR

THE CHALLENGES OF WORKING WITHIN SCHOOL SYSTEMS:
APPLICATIONS OF SYSTEMS THEORY TO A SECONDARY
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Abstract

Since the 1970s Educational Psychologists (EPs) have been writing about and discussing the ‘traditional’ perception of their role as assessing and working with individual children versus more effective and preventative ways of working within schools using systemic and organisational approaches. This report provides a brief overview of the history of the profession of educational psychology and the significant developments in legislation and policy which have shaped current professional practice. The background to and the key concepts of systems theory are outlined. A secondary school behavioural case study is presented, and as a result of this, systems thinking is used to identify opportunities for systemic work within the school. The key concepts of systems theory are then applied to the case study post hoc in order to understand why the school did not take up the recommendations of the Educational Psychology Service, made at both an individual and systems level. This report concludes by discussing how helpful the application of systems theory was in understanding resistance to change in the case study, and by reflecting generally on why EPs develop few opportunities to work at an organisational level within schools.

THE CHALLENGES OF WORKING WITHIN SCHOOL SYSTEMS:
APPLICATIONS OF SYSTEMS THEORY TO A SECONDARY
SCHOOL BEHAVIOURAL CASE STUDY, IN ORDER TO
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SYSTEMIC LEVEL WITHIN THE SCHOOL DID NOT OCCUR

1. Introduction: The Role of the Educational Psychologist

1.1 A Historical Overview of Educational Psychology in England and Wales

The scientific discipline of 'Child Study' in the UK is reported to date back to 1884 and 1896 when the laboratories of Francis Galton and James Sully opened in order to carry out experiments and research on 'difficult' children (Boyle et al, 2008). However Cyril Burt, (1964, cited by Dessent, 1978) who was appointed as the first 'educational psychologist' (EP) in 1913 to London County Council, asserts that the need for an educational psychology service arose from the introduction of the 1870 Education Act which required independent schools to admit children with behavioural and learning difficulties whom they may have previously rejected. As a result of these changes specialist educational provisions were set up, producing the need for a system to identify which children should attend these (Dessent, 1978). An answer to this dilemma arose from the pioneering work of individuals such as Galton, Binet, Pearson and Burt who initiated the development of psychometric assessment, in combination with the claim made by the Board of Education that all children with IQs under 70 required specialist provision. Dessent (1978) suggests it is this juxtaposition of events

‘that can be regarded as the historical roots of the profession of educational psychology’. p.27

Cyril Burt’s appointment was followed by a slow growth in the employment of EPs due to financial constraints (Wooldridge, 1994); however numbers in the profession increased with the introduction of the Child Guidance Model of practice from the US in 1927, which shifted practice from focussing on psychometrics and individual differences to the psychodynamic treatment of ‘maladjusted’ children, in partnership with psychiatrists and social workers (Boyle et al, 2008).

The next significant development in the profession of educational psychology occurred with the publication of the Summerfield Report (DES, 1968) which focussed on the work of EPs, and the qualifications and training needed to do it. It revealed that the majority of EPs’ time was spent assessing children in schools and other settings, as opposed to Child Guidance Clinics (Dessent, 1978), and that the dominant activities involved individual diagnostic, clinical or therapeutic work, as opposed to preventative work, or in-service training. The report recorded the ‘unique contribution’ of EPs as being able to provide both a psychological and educational assessment of children’s needs, and became known as a ‘handbook’ of the practice of EPs’ in England and Wales (Boyle et al, 2008).

During the 1960s/70s there was increasing unease in the Educational Psychology profession concerning ‘traditional roles’ of EPs in schools and thoughts on how these should change were aired in a number of publications including ‘Reconstructing Educational Psychology’ (Gilham, 1978). Within this text Dessent summarises the causes of dissatisfaction as including

the ineffectiveness of individual psychotherapy, the inadequacies of intelligence testing and the need for assessment to provide information that could be used positively to inform intervention, rather than merely allocating children to categories of deficit. The 1981 Education Act, which was informed by the Warnock Report (DES, 1978) was the next step towards the educational psychology practice with which we are currently familiar.

The 1981 Education Act advocated a change in the concept of special provision as a location, such as the ‘special school’, to a more inclusive view in terms of additional support that could be provided in mainstream schools. The introduction of the Code of Practice (DfE, 1994; DfES, 2001) established systems for schools and EPs working with children with SEN and the 1994 Education Act provided the means of challenging decisions through SEN tribunals (Boyle et al, 2008).

1.2 Current Role of Educational Psychologists in England and Wales

In 2000 a government appraisal of the current and future role of EPS in England was carried out and concluded that the main contributions of EPs were,

‘to promote child development and learning through the application of psychology by working with individual and groups of children, teachers and other adults in schools, families, other LEA officers, health and social services and other agencies. (DfEE, 2000, p.5)

Boxer et al (1998), in an earlier paper, refer to the ‘application of psychology’ as allowing EPs to work more freely beyond the demands of statutory work and following the Code of Practice (DfES, 2001). However the Code of Practice (DfES, 2001) is not wholly limiting to educational psychology practice because it recognises the importance of EPs and their

knowledge of the context of the schools they work within as an ‘important resource’, as well as emphasising that EPs can work at a

‘whole school level, for example helping to develop knowledge and skills for school staff and assisting with projects to raise achievement and promote inclusion’ (DfES, 2001, section 10.8).

The introduction of the Every Child Matters (ECM) (DfES, 2004) in England and Wales further supported the development of EP practice by its emphasis on multi-agency working, which lead to the restructuring of Children’s Services in many Local Authorities (LAs), often with integrated teams of professionals being formed. Farrell et al (2006) assert that changes brought about by ECM (DfES, 2004) reflect the evolving and increasingly diverse role of educational psychology services, which have altered greatly from those outlined in the DfEE (2000) report on the role of EPs. In their detailed report on educational psychology service delivery, in which the views of EPs, schools, parents and other professionals were sought, Farrell et al (2006) found that service users viewed EPs as making distinct, ‘effective contributions’ to multi-agency work. There was also evidence of EPs doing less statutory work than in the past, and a greater range of ‘effective SEN work’ which allowed them to contribute to the five outcomes of ECM. One of the barriers to effective service delivery identified was a lack of time with school staff which Boyle et al (2008) suggest has lead to a prominence being placed on systemic work and consultation within schools, ‘which is arguably more time efficient than working with individual children’ and then feeding back to their teachers (p.40).

It is within the context set out above that the piece of casework described and discussed within this report is placed, particularly recommendation 3b of the Farrell et al (2006) report which suggests EPs should use the time freed up by a reduction in statutory work to

‘expand and develop their activities in different areas where their skills and knowledge can be used to greater effect’ (p. 106)

particularly working at a systems level within schools and organisations.

1.3 The Advantages of Working at a Systemic Level within Schools

For more than 20 years following the seminal works of Gillham (1978, 1981) EPs have been writing about the advantages of working at a systemic level (Stratford, 2000). This approach to service delivery aims to support schools to focus on common problems shared by staff, provide strategies for managing these and bring about changes which affect all pupils, therefore

‘the need for many individuals to be seen and dealt with separately by a psychologist will be reduced and the quality of education for the majority will be improved’. (Stratford and Cameron, 1979, p. 57)

One advantage of working systemically within schools is summarised by Stoker (1992) who reiterates the argument of Cameron and Stratford (1979) and others involved in the ‘reconstructing movement’. Stoker suggests that with the completion of each successful piece of individual casework a new referral will be identified by the school until the EP looks behind the presenting problem at the organisation and systems within the school that are maintaining or producing it.

Gillham (1981) asserts that individual casework cannot meet the needs of schools because the effectiveness of 'treatment' interventions will always be limited whilst there is evidence that the number of pupils considered to be 'deviant' by their teachers increases in line with the availability of resources to meet the needs of such children. Miller (2003) states that attempting to understand problems in the classroom or school through linear causation can lead to ineffective intervention and argues for the concept of circular causation which recognises that schools are complex human systems, within which behaviours takes place.

However a number of researchers suggest that government policy and legislation advocates 'within child' and individual casework approaches to working in schools. Souter (2001) argues that in the Elton Report (DES, 1989), the strategies outlined for managing disruptive behaviour, overlooked any 'theoretical understanding of the nature of the problems' (p.37), whilst Upton and Cooper (1990) claim that teachers and policy makers ignore theories which divert from a medical model.

This professional practice report introduces the key concepts of general systems theory as a framework for EPs to aid understanding of problem situations and working at a systems level within schools. A case study of a secondary school pupil close to exclusion because of challenging behaviour is presented and opportunities for working at a whole school level, in relation to the case, are identified. The key concepts of systems theory are applied to the case post hoc in order to understand why the school did not act on the suggestions made by the EPS and why this particular piece of individual casework did not progress into more effective systems work within the school. The report concludes by considering the helpfulness of

systems perspectives and the challenges and resistance EPs face when trying to bring about change within school systems.

2. Key Concepts of Systems Theory

2.1 Systems, Systems Theory and Systems Thinking

Ackoff (1960) defines a system as ‘any entity, conceptual or physical, which consists of interdependent parts’, whilst Campion (1985) describes a system as,

‘a collection of continually interacting parts which together make a whole which is more than the sum of its parts. There is a tendency for each part to affect, and in turn be affected by, all other parts in the system.’ p. 42

Systems theory is founded within biology and the physical sciences (Miller, 2003) and is a ‘generic term’ based on the concept of ‘interacting units or elements making up an organised whole’ (p.431) and is underpinned by general systems theory and cybernetics (Goldenberg and Goldenberg, 1996).

General systems theory asserts that all living systems are maintained through the interaction of their different parts. A system is defined by its organisation and the transactions that occur between its parts; therefore in order to understand a system it is necessary to study the interactions that occur within it (von Bertalanffy, 1968).

One idea central to general systems theory is the concept of open and closed systems (Dowling, 1994); von Bertalanffy (1950) asserts that all living systems are open systems, and

are therefore dependent on a constant interaction with their environment in order to maintain themselves (Katz & Khan, 1969). Cybernetic theory, first described by Wiener (1948) is concerned with how a system is maintained and self-regulated by using feedback mechanisms to process the information it receives (Souter, 2001). An example of this is circular causality which requires sequences of interactions and the ‘how’ of why a phenomenon or problem is occurring to be considered, in contrast to linear causation which looks for unidirectional cause and effect relationships in order to explain effects (Dowling, 1994) (see Section 2.4).

Frederickson (1990a) points out the need to differentiate between systems concepts which are derived from the biological underpinnings of systems theory, which are commonly used in family therapy, and those concepts which are based on the cybernetics approach, and take a technological perspective, such as soft and hard systems methodology (see Section 2.2.).

It is important to recognise the ‘loose’ use of the terms ‘systems approaches/thinking’ and ‘systemic/systems work’ within professional EP talk, and to clarify the meaning given to them within this particular report. Fredrickson (1990a) emphasises that a large number of different practices are labelled ‘systems approaches’, and that these may only have in common the fact that the EP is not working directly with individual children.

The term ‘systemic’ refers to

‘using systems ideas; treating things as systems or from a systems viewpoint; pertaining to a system or systems’ (Open University Systems Group, 1981, p.18.)

Fredrickson (1990b) emphasises that systemic approaches and systems thinking should not be confused with systematic work with groups or organisations, as these are not always guided

by key concepts of systems theory. Similarly, systemic thinking and components of systems theory are not only used for whole school work, but can be applied when attempting to understand problems at an individual or group level.

Often the phrase ‘systemic work’ is used interchangeably with ‘organisational work’ when referring to projects carried out by an EP within a school. However ‘organisational work’, although it occurs at an organisational level within a school, as opposed to individual casework, and may result in changes in the systems within the school, does not necessarily involve the applications of the key concepts of systems theory. In the current case study the terms systems thinking or systems theory are used at two different levels. Systems thinking is used in relation to the case study to describe my approach to working with X, for example, taking into account the different systems she was part of in the formulation of the problem dimensions, as opposed to using a ‘within’ child approach, and identifying opportunities for change within the school’s system as a result of the case. Systems thinking is also used retrospectively in the application of key components of system theory to the case study in order to understand the school’s resistance to change.

2.2 Hard and Soft Systems

There are two complementary schools of thought within systems thinking, hard and soft systems. Checkland and Scholes (1990) argue that this distinction is used to describe the types of problems tackled; for example, hard systems methodology is concerned with addressing well defined problems related to the formal structure of organisations, whilst soft systems methodology (SSM) is designed to address ‘messy, ill-structured, problem situations’ (p.22). However these two schools of thinking also differ slightly in their methodological approaches;

hard systems thinking assumes that the perceived world is made up from 'holons', a word used to describe a system as a whole, whilst soft systems thinking states that the process of enquiry can itself be a 'holon'. SSM, which is used across a variety of organisations, was developed by Checkland (1981) and introduced to educational organisations by Fredrickson (1990d) and involves the use of a systemic process of enquiry, which makes use of systems models (Checkland & Scholes, 1990).

2.3 Boundaries and Open and Closed Systems

There are two types of system, those which are closed and those which are open to their environment. Closed systems are self-contained and are found in the physical sciences, such as mechanistic organisations, whilst open systems tend to be biological or social and have a dynamic relationship with their environment (Kast & Rosenzweig, 1981). Classrooms and schools are examples of open systems because they are influenced by other systems such as the Local Authority and society (Souter, 2001). Open systems not only interact with their external environments, interaction occurs internally between their components, allowing them to change their organisation in order to adapt to the environment (Kast & Rosenzweig, 1981).

The concept of an open system being in a constant state of exchange with its environment creates a need for boundaries to be drawn in order to understand the scope of the system that is being considered or worked within. Closed systems have 'impenetrable' boundaries, whilst open systems have 'permeable' ones. Kast and Rosenwzeig (1981) describe boundaries as,

'demarcation lines or regions for the definition of appropriate system activity, for admission of members into the systems and for other appropriate imports....a barrier for many types of interaction between people on the inside and people on the outside.' (p.50).

It is important to understand the boundaries of the system you are working within, for example when carrying out an intervention within a school; parents, the community, and dinner staff may be included within the boundaries of the system depending on how the problem is perceived.

2.4 Circular Causality and Punctuation

As introduced in Section 2.1, circular causality is a key concept of systems theory, and one that is invaluable to family therapists because it prevents blame being ascribed through the use of linear causality and instead looks at cycles of interaction and how there are reciprocal influences within these cycles (Dowling, 1994). Dowling (1994) refers to Bandura's (1969) claim that a reciprocal interaction occurs between behaviour, its consequences and the environment in which it takes place, which can lead to a maintenance of that behaviour or a change in it, depending on the consequences. Therefore a system maintains its own functioning through multidirectional feedback. A simplistic example of this in a classroom situation could be where a pupil who is struggling with their work is viewed by the teacher as lazy, which affects the level of work which she sets him and her expectations of him; because the teacher does not encourage him to complete his work or give him positive feedback, the pupil does even less in lessons, which in turn reinforces the teacher's views of him.

Using the classroom example presented above, where both the teacher and pupil play a role in 'feeding' the beliefs and behaviour of the other, when each participant gives their perspective on the problem situation, this is often referred to by family therapists as the punctuation point (Miller, 2003). Dowling (1994) explains it as 'the point at which a sequence of events is

interrupted to give a certain meaning' (p.5); depending on where the punctuation occurs, either party's behaviour may seem more reasonable, provocative or unhelpful than the other person's. No punctuation is right or wrong, it just presents different views of reality. Miller (2003) suggests that for effective intervention to take place it is necessary to find a 'mutually acceptable' punctuation point; if intervention is based on only one view of the situation, then this is likely to further increase the negative cycle of interaction.

2.5 Homeostasis/ Dynamic Equilibrium and Feedback Loops

Homeostasis is another term that was first used in the physical sciences which describes the tendency of living organisms to move towards a state of equilibrium (Cannon, 1939, cited in Dowling, 1993). Kast and Rosenzweig (1981) explain that there is a dual meaning behind the term 'equilibrium' when it is applied to a system. Firstly open systems remain in dynamic equilibrium through the continuous exchange of material, energy and information which they have with the external environment. This allows the system to adapt to changes in the environment whilst maintaining a steady state. Analogies can be drawn with the human body and its ability to maintain a constant internal temperature when the external temperature changes, and across differing levels of energy consumption and expenditure. Secondly systems maintain equilibrium within their various internal subsystems or parts so that the whole system performs effectively. Social systems differ slightly from biological systems because they can not reach

'an absolute steady state, but rather a dynamic or moving equilibrium, one of continual adjustment to environmental and internal forces'. (p.51)

Dowling (1993) discusses a concept adopted by family therapists where a member of a family is 'sacrificed' to maintain homeostasis, or in other words a negative role is fulfilled by a member of a system in order to preserve the status quo and prevent the system being challenged. This can be seen in some schools where although numerous interventions are carried out or challenging pupils are excluded or move provision, new children with behavioural or learning needs are often identified in their place (see discussion in Section 1.3). In such cases it could be argued that there is something within the school system which acts to maintain this behaviour, even if it is carried out by different individuals. Gillham (1981) suggests that all behaviour within a school is kept going by the task and role demands on pupils and teachers; such a theoretical argument should have the effect of broadening the focus of the problem from an individual to a system level (Souter, 2001).

The process of feedback, through which an open system is constantly receiving information from its constituent parts and its external environment, informs the necessary adjustments to maintain dynamic equilibrium within the system (Kast and Rosenzweig, 1981). Feedback loops occur between systems when each link or stage in the loop is influenced by its interaction with the other links, producing a reciprocal relationship which determines how the systems view each other (Dowling, 1993). This can be seen in the relationship between families and schools; one example may be where parents view teachers at a school as unapproachable and so do not communicate with them regularly, which feeds the teachers' perception of parents being uninterested and so they, in turn, are less likely to make themselves approachable or to initiate communication.

3. Common Elements to Social Systems

3.1 Hierarchical Organisation, Policy and Procedure

Dowling (1993) asserts that all social systems, including schools and families, have a hierarchical organisation which is defined by a number of different boundaries, such as generational and hierarchical boundaries, and those between subsystems. For example within a school, hierarchical boundaries may divide the Senior Management team from class teachers, whilst generational boundaries may divide ‘experienced’ and ‘new’ members of staff. Boundaries may also exist between subsystems such as teaching assistants and lunch-time staff, or between the science and humanities faculties. When working within a system it is important to be aware of how the sub-systems within it are formed and who constitutes the executive subsystem, which makes decisions relating to policy and rules, thus affecting how the system functions (Dowling, 1993).

Stratford et al (2000) assert that all successful social organisations have a vision, mission statement, a set of collective values, clear boundaries/rules and methods of monitoring these and acceptable ways of doing things which are influenced by its culture. Sutoris (2000) differentiates between three of these concepts by asserting that the mission statement is the operationalisation of the school’s vision, and together they form the school’s aim. Rules exist to direct the way individuals behave and relate to each other within a system. Dowling (1993) emphasises the difference between ‘said’ and ‘unsaid’ rules which Gorrell Barnes (1982) describes as ground rules and metarules. The former are clearly stated and relate to how the system functions, whilst the later are ‘unsaid’ rules ‘about the meaning of the ground rules’ (Dowling, 1993, p.9). Schools are required to have policies, which could be described as

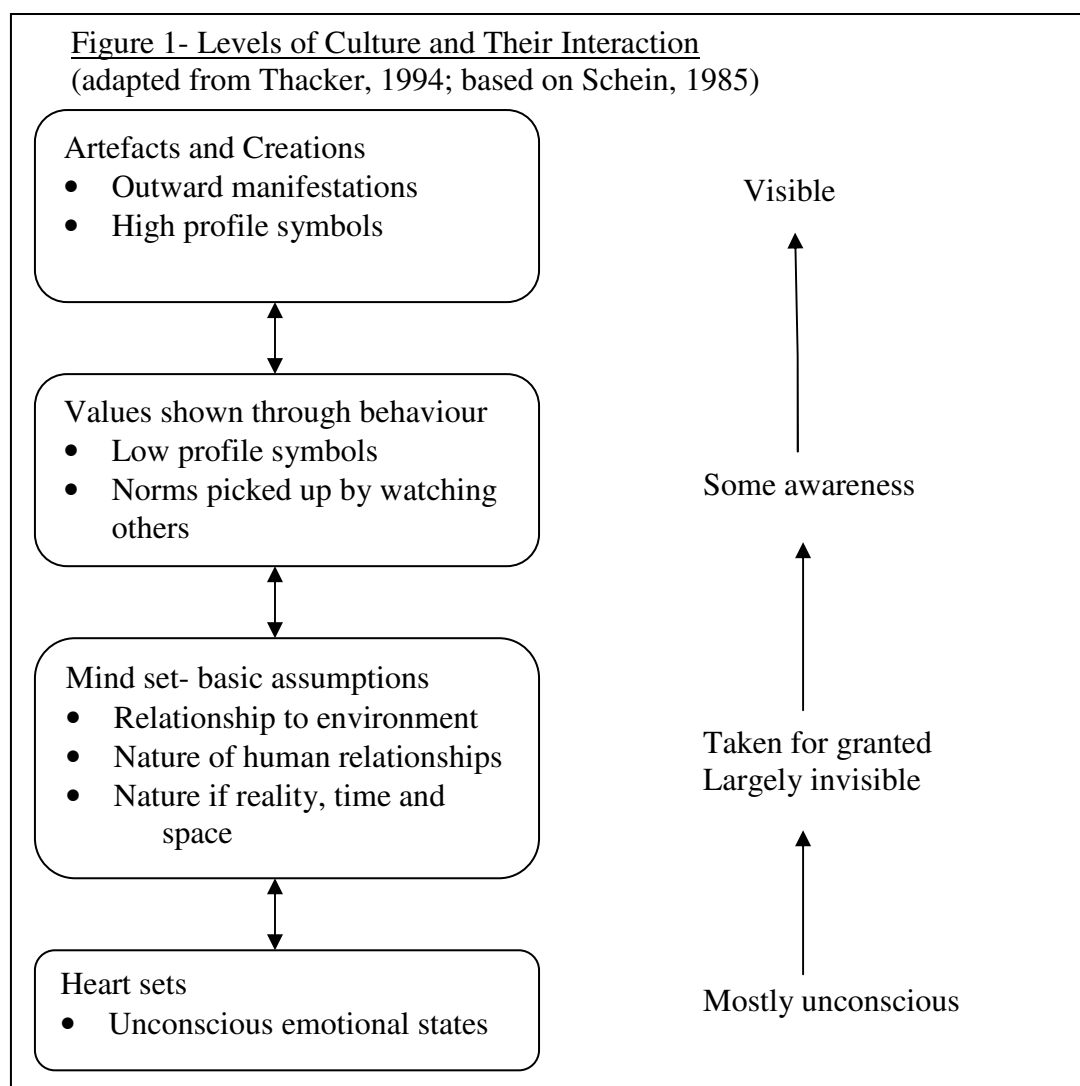
official recordings of ‘ground rules’ and are often used during inspections or evaluations in order to monitor the school’s practice and accountability. Miller (2003) includes both formal written statements that are publicly available and procedures that are recognised as ‘normal’ for the school within the term ‘policy’. Disparity between policy and actual teacher practice is discussed in Section 3.2.

3.2 Culture and Belief Systems

Thacker (1994) describes school organisational culture as the beliefs and expectations of the school and how people within it relate to each other, set within an awareness of the school’s history. In short it is ‘the way we do things and relate to each other around here’ (p.11). Schein (1985) describes culture as a ‘pattern of basic assumptions’ developed in response to challenges, which have been adopted by members of the organisation and are passed on to new members because they are viewed as effective and valid. Schein (1985) suggests that there are four different levels of culture which interact with each other (see Figure 1), and become increasingly less visible to those on the outside, and even those within the organisation.

Schein (1985) asserts that high profile symbols are the most accessible part of a culture as they are present in the most visible layer. These are school mission statements, uniforms, building and classroom layout, and the way the school is presented to outsiders. The next layer is formed by the day to day reality of lived experience within the organisation. Here it is in the habits and conventions of staff and pupils, that what is learnt in order to ‘fit in’, is found. The next two layers are formed by the basic assumptions of the people who make up the organisation. The third layer is made up from the mind set or assumptions of the

organisation's leader and influential group members. In relation to schools, these are the basic attitudes of the head teacher and leadership team towards 'the basic nature of children' (Thacker, 1994, p.13). Finally the deepest level is that of 'heart sets', which are formed by individuals' personal early childhood experiences. These are the foundation of the three higher levels of culture and are considered difficult to change because of they are often held at an unconscious level.



Argyris and Schon (1978) draw a distinction between 'espoused theory' and 'theory in use' when describing cultures and claim that analysis of the gap between these is essential for

understanding organisations (Jensen et al, 2002). The first level of Figure 1 represents cultural symbols which are within the espoused theory; these are formal, publicly available statements about how the organisation functions (Miller, 2003) or about how people would like to think of their organisation (Thacker, 1994). However in practice there is often a noticeable difference between an organisation's 'espoused theory' and their 'theory in use', which is formed by hidden cultural rules about the way things are done, and which members are influential (Miller, 2003). Argyris and Schon (1978) emphasise that organisations are practised at concealing gaps between their 'espoused theory' and 'theory in use', as revealing such a difference may cause problems amongst members and undermine the organisation's reputation. It may also upset the internal stability/ homeostasis of the system.

In summary, the key components of systems theory and the common elements found in social systems are briefly described in Sections 2 and 3 respectively. This theoretical orientation, when applied to problem situations, should prevent simplistic linear assumptions of causality being made and provide a 'blame-free' environment where the complexity of behaviour in context is recognised. Differing punctuation points allow for all viewpoints to be legitimate; however a 'mutually acceptable' punctuation point is needed for change to occur. Homeostasis and feedback loops, underpinned by the organisational hierarchy and culture of the system, provide insight into the processes and consequences of change, and why it may, or may not, take place. All of the components of systems theory can be applied to help make sense of problem situations on an individual, family, organisational and societal level.

4. Case Study

4.1 Referral and Negotiation of Work

The current case study is of the young person X, a girl, who was commencing Year 9 at the time of referral, in a relatively large Local Authority Girls' School. X was raised as a concern in the September planning meeting attended by myself (TEP) and the School's Visiting Educational Psychologist (VEP) because she was close to exclusion due to challenging behaviour in lessons and aggressive outbursts towards staff and other pupils (see Table 1 for referral information). The Educational Psychology Service had no previous involvement with the pupil at primary school or through consultation with her current school's SENCO in Years 7 and 8. An initial information collecting meeting with X's Head of Year resulted in the identification of the following priorities for the school:

- to help X acknowledge her behaviour and the effects it is having on others;
- to gain an understanding of the influences on X's behaviour; and
- to prevent her exclusion from school.

It was agreed that I would observe X in a lesson and feed back to the SENCO about the current behaviour strategies being used, and others which may be effective. Then a number of sessions of individual work with X were agreed upon, in order to gain her perspective on school and her behaviour (see Appendix 1 for further information re: management of Case X).

Table 1: Information about Pupil X Provided on Referral

Areas of Need	Referral information
Learning and Concentration	<ul style="list-style-type: none"> • X's learning is described as poor; her levels of achievement are below the expected national average for a student of her age, and she particularly struggles with reading. • X frequently talks and calls out in lessons. She rarely completes the work set.
Interpersonal Skills with Adults and Peers	<ul style="list-style-type: none"> • On a one-to-one basis X can communicate well with some adults; however she can be verbally aggressive and defiant when challenged. • Teachers describe X as having a small group of friends, although many of her peers are reportedly intimidated by her. She has previously been excluded for fighting.
Personal, Social, Emotional and Behavioural Needs	<ul style="list-style-type: none"> • X gets very angry when challenged by teachers or other pupils; she is often late for lessons or 'storms out' of them. • The school expressed concerns about 'inappropriate peers' she spends time with out of school. • X has attended a 6 week 'behaviour course' at a Behaviour Support Services centre during Year 8, which addressed anger management and social skills. • X shows little respect for her mother, who has been called into the school for meetings.
Understanding and Use of Language	<ul style="list-style-type: none"> • X is very articulate and able to express herself, particularly on a one to one basis, very well. She often contributes to discussions in literacy lessons, but then struggles to present her ideas in a written form.
Medical Needs	<ul style="list-style-type: none"> • The school reports that X has no known medical needs
Provision in School	<ul style="list-style-type: none"> • Currently X has weekly 15 minute sessions with a teacher from the Behaviour Support Service. These are used to support reflection on any behaviour incidents recorded during that week. • X is on behaviour report, where 3 targets are identified and

	<p>every lesson the teacher records if these have been met and to what extent.</p> <ul style="list-style-type: none"> • X is on a pastoral support plan which ties in with the targets on her behaviour report. This includes the support outlined above and the daily collection and dropping off of her behaviour chart with her Head of Year • X is in the lower ability groups for literacy and numeracy, where she is taught in a group of approximately 15 other pupils. • X is at School Action Plus on the SEN register.
Additional Background information	<ul style="list-style-type: none"> • X joined her current school late in year 7 because of moving house; she was involved in a fight with another pupil soon after arriving, and feels this has influenced teachers' perceptions of her. • X lives at home with her mother and older sister, who has 2 children under the age of 3 years.

4.2 Identification of Problem Dimensions in Case X

Pupil X willingly talked about school and her home life during one to one sessions with me. She always attended on time and expressed that she found it helpful to talk to someone about what was happening in her life (see Table 2 for summary of work with X). X was usually willing to answer questions, and a relatively open relationship was formed where X disclosed personal information about her relationships with members of her family, other pupils and school staff. I provided feedback to the SENCO on a weekly basis, without compromising the confidentiality of our sessions, concerning the pressure X was experiencing at home and in school, and ideas or strategies that I believed may help X with her behaviour, such as consistent use of her chart, and giving her time to respond to instructions.

It became apparent through discussions with X and key members of staff, as well as from her behaviour record, that some of the behaviour systems within the school, and particular relationships with and management by certain members of staff were provoking or intensifying X's negative experiences in school and hence her challenging behaviour. She also reported that her relationship with her mother, older sister and brother was strained, and that she found having her two young nephews living at home difficult. X was spending a lot of time on the streets with peers, rather than at home because of the arguments she was having with her mother. X reported that she felt she was a 'trapped' between her mother, who was attempting to seek custody of the two nephews, because of their mother's alcohol problems, and her sister and older brother, who had left home. X was able to talk with insight about her behaviour, and how her level of resilience and response to confrontation at school was often influenced by her home life.

Table 2: Record of Work Carried out in Case X

TEP Involvement	Identified Purpose
Meting with Head of Year	Information collection and agreement on direction of work.
Lesson observation	To identify triggers for and purposes of behaviour To assess which behaviour management techniques used in the classroom are effective, and what other strategies could be employed.
Session 1- individual work	Explanation of role and relationship building. Identification of X's best and worst lessons. 3 comments work- elicitation of how X believes significant others in her life view her by asking her three things they would say about her.
Session 2- individual work	Exploration of X's perceptions of herself- Ideal Self. Discussion about reputation and how others perceive her.

Session 3- individual work	Overview of behaviour that week. Identification of the positive and negatives of being in school.
Session 4- individual work	Identification of what influences X's mood and behaviour.
Session 5- individual work	To set targets and identify what will help X to maintain her improved behaviour.
Session 6- individual work	Discussion of school holidays and return to school. Prediction of possible threats to improved behaviour. Conclusion of work together.
Meeting 1 with key members of staff	Opportunity to feed back of work done with X and represent her views. Discussion about next steps for X.
Meeting 2 with key members of staff	Opportunity to feed back of work done with X and represent her views. Discussion about next steps for X.
Meeting 3 with key members of Staff	Discussion about implications of casework with X for the school's behaviour management and systems.

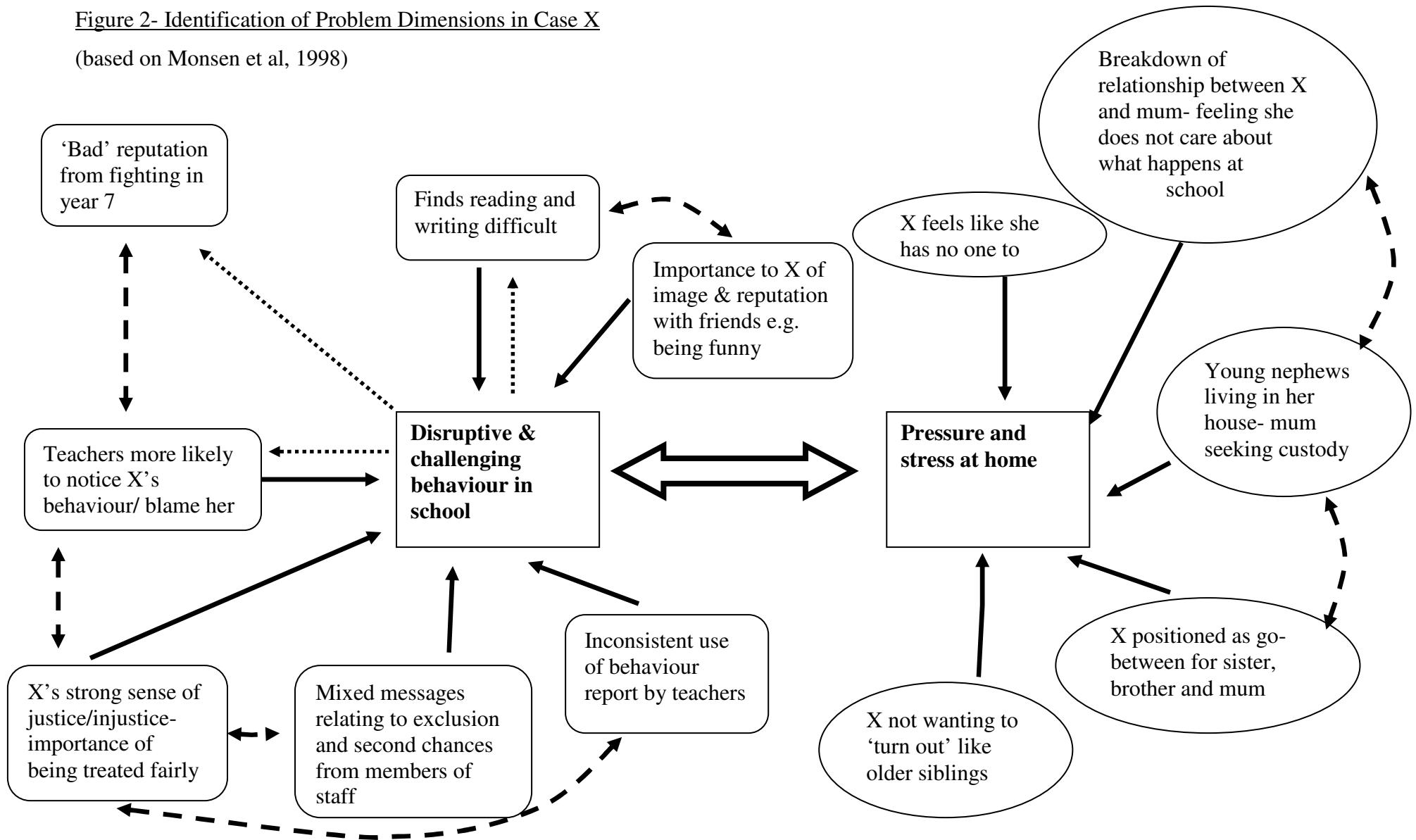
Although there was an improvement in X's behaviour over the six week intervention period, which was demonstrated through her behaviour record, several of the key members of staff who had regular contact with her did not accept this, and presented the view that she could not remain in the school because of the exceptions being made for her, in the form of extra adult support and 'new' chances, and the stress she was causing some members of staff. X was receiving mixed feedback relating to her behaviour, with threats of exclusion from one member of staff and reassurance from another that this would not occur. X's Head of Year was particularly negative about her and daily checking of X's behaviour record by this teacher in particular often ended in confrontation. In contrast to this X's Deputy Head of Year got on very well with her and was able to manage her behaviour and keep her engaged in lessons.

According to X and the Head of Pastoral Care there was differing practice relating to the use of her behaviour chart, with specific teachers with whom she ‘clashed’ often marking all three targets as failed, because of one negative behaviour in class. X had a strong sense of fairness, and, from her perspective, such incidents would often lead to her confronting staff and leaving lessons. Figure 2 summarises the problem dimensions identified through my work with X and demonstrates how they may interact with, or relate to, each other. My analysis of the problem dimensions is based on step five of Monsen et al’s (1998) nine step Problem Analysis Framework (PAF). The PAF claims to reduce the complexity of a case whilst structuring and analysing the information involved to make it easier for the EP and those involved to understand (Monsen et al, 1998). One method of doing this is by presenting the problem dimensions as a ‘map’ (step five) showing how they influence and impact each other (see Figure 2). Monsen et al (1998) identify the problem dimensions by collecting information from the stakeholders to either challenge or support guiding hypotheses. In the current case study, all of the problem dimensions are hypotheses which were identified during one to one work with X or through discussion with the key members of staff involved with her, and which were then shared with and confirmed by X.

In order to present the problem dimensions in an organised form, two key areas, ‘disruptive and challenging behaviour in school’ and ‘pressure and stress at home’ were identified, and the remaining problem dimensions are presented around these with arrows demonstrating how they may interact with each other.

Figure 2- Identification of Problem Dimensions in Case X

(based on Monsen et al, 1998)



The completion of my individual work with X, and the mixed views amongst staff as to whether there had been a ‘real’ improvement in X’s behaviour and her future at the school, led to a meeting for staff involved with X. The school’s VEP and I hoped this would be an opportunity to share some of the systemic problems which had been suggested through working with X, rather than taking a ‘within’ child approach to X’s behaviour. In order to do this we requested that the Head of Pastoral Care attended the meeting, along with the School’s VEP, the SENCO, Deputy Head of Year, Head of Year and myself.

4.3 Summary of Meetings with Staff in Relation to X

Three meetings were held to discuss X. The first two were attended by all the key members of staff listed above. However the final one was attended by only the VEP, the Head of Pastoral Care and myself. The opportunity for the school’s VEP to meet with key members of staff in relation to a pupil had not occurred before, and the VEP had felt that she was limited to meeting with the SENCO only, even though behaviour cases were often discussed with her. From my perspective, the first two meetings were dominated by the Head of Year’s negative attitude towards X and her feelings that X could no longer remain in the school (see Appendix 1 for summary of meetings). Not until the second meeting was I given the opportunity to share the work I had done with X, and to represent her perceptions of school. Throughout these meetings it became clear that there was poor communication between the Head of Pastoral Care and the Head of Year in relation to how they managed X, and this seemed to reflect a general lack of communication and a poor working relationship.

Within the meetings, discussions were held about referrals to other agencies and the use of a reduced timetable over a short period of time to limit the number of negative experiences X was having in school. By the time of the third meeting, which occurred approximately two months after the first, none of the recommendations had been followed through. From my own and the VEP's perspective, the purpose of the final meeting with the Head of Pastoral Care was to discuss discrepancies in the behaviour system that were highlighted by X's case, and any further support the Educational Psychology Service could offer in relation to this. At the meeting we were given the opportunity to illustrate how, in our opinion, the school's behaviour system was contributing to some of X's behaviours, and how a lack of records and evidence of the school's intervention made it difficult to judge if a pupil's behaviour was improving or if their needs may be better met in another provision. However the Head of Pastoral Care kept bringing the discussion specifically back to X, and a medical model, asking if her behavioural needs were beyond those which a mainstream school should be expected to meet.

Following the final meeting, a summary of my involvement with X was sent to the school (see Appendix 1), and the offer of continuing to meet with the pupil on a fortnightly basis, in order to provide someone for her to talk to about home and school, was made. The school did not take me up on this offer and pupil X was not raised by them for the remainder of the term, nor was she excluded.

Within the following section I will apply the key concepts of systems theory (see Section 2) to the case study of pupil X and use these, in conjunction with the characteristics of systems (see Section 3), to reflect upon the usefulness of this approach in understanding

the complexity of the case, and why the recommendation made by the EPS, and the opportunity for systemic change, highlighted by the situation, may not have been taken up by the school.

5. Application of Systems Theory to the Case Study

5.1 Formation of Boundaries within the Case Study

Miller (2003) describes how EP involvement in schools can lead to the formation of temporary and overlapping systems, which are described in Family Therapy as ‘therapeutic suprasystems’ (De Shazer, 1982). Miller (2003) suggests that if school staff perceive a new system based on the formal involvement of the EP, containing also the teacher, child and parent, they are more willing to try new behaviours which may differ from the norms within the school system. Trying out such strategies and behaviours within this temporary system allows the teacher to construe the child or problem situation in different ways and can prevent internal strain occurring as a result of the school system trying to maintain homeostasis. This temporary system ceases to exist when the EP is no longer involved, and the school systems remain intact. However Miller suggests that the new practice trialled during the intervention period can still continue, as it is viewed as being the responsibility of the EP, even when they are not physically present.

Miller’s (1994; 2003) Successful Strategies research, on which he bases the above assertions, can be subject to criticism because of the sampling methods used to identify the teachers who were interviewed. This study considered in detail 24 successful interventions that took place in primary schools throughout England, where each involved an EP

working with a teacher to develop strategies for managing the difficult behaviour of a student (Miller, 2003). A grounded theory approach was adopted, and an 'open coding' approach applied to interviews with members of staff. Participants were selected by EPs who were asked to provide the names and schools of teachers whom they had worked with successfully to carry out an intervention from a behavioural perspective. Although the teachers had to agree that the intervention was successful, it could be argued that their responses may have been influenced by the fact they were 'chosen' and so wanted to give answers that met the expectations they perceived the interviewer to hold. Because Miller's findings are based on his interpretation of the interview data, it could be argued that this degree of subjectivity undermines their validity. Miller (2003) describes the interview process as using open questions and encouraging reflection. He then takes quotes from the interviewees, relating to their work with EPs, and uses these as evidence of the formation of new systems during the intervention period.

In the case study one such temporary system contained X, the VEP, the four key members of staff who attended the meetings and myself. The formation of the system did allow new ideas and behaviours to be explored to an extent. For example, this case was the first time when all the key members of staff had been brought together in consultation with an external agency to facilitate the sharing of views and ideas. Although this may seem like a logical step to take in order to intervene effectively with X's behaviour, the 'theory in use' in relation to the management of special needs and behaviour within the school, was that the SENCO dealt with external agencies, and filtered the relevant information through to members of staff. There may be several reasons for this approach; consultation with external agencies may be viewed as a step in a process leading to statutory assessment or

change in placement, rather than a process in which the school has a more active role. It could be that the practicalities of such meetings are challenging and that it is not a priority for the school to free up staff time so they can attend. School staff could perceive the EP's role as working to bring about change 'within child' rather than working with staff to look at ways in which they can change child and classroom behaviour. The objectives identified by key members of staff for my involvement with X and their suggestion of individual work with her, could be interpreted as evidence of such a culture within the school.

X's mother was not part of the system formed by my involvement with the case study, although she had previously attended several meetings called by the school in relation to X's behaviour. I think the intervention may have been more effective, in terms of support for X if her mother had been part of the temporary system, because she may have had the opportunity to understand the pressure X was experiencing because of her home-life, and how this was impacting on school. However the school staff's unwillingness to recognise their part in X's behaviour is unlikely to have been improved by this, and indeed it may have confirmed their views that X's behaviour is influenced by her life outside of school, rather than the school systems.

5.2 Circular Causality and Punctuation Points in the Case Study

The reciprocal interactions maintaining X's behaviour and staff responses to this, are represented in a simplified form in Figure 2. One example is the differential use of her behaviour record, where according to X, and recognised by the Head of Pastoral Care, some members of staff would give her low marks for all three targets because they were annoyed about one of the behaviours she had displayed in their lessons. From her own

perspective, this could result in X storming out of the lessons or arguing with teachers, which would then confirm their low expectations of her, and perhaps make them more likely to make harsh judgements against her targets next time. In response to this X may also feel she will not be able to succeed in that lesson because of the teacher's attitude towards her, and therefore may be less likely to try to achieve her targets.

In order to break the circular causality by changing the negative reciprocal influences which are maintaining the behaviours described above, the cycle needs to be punctuated at a point which allows all parties to have some understanding of their role in it. Miller (2003) describes this as,

‘a mutually acceptable punctuation point, at which the influence of each party on the other can be seen to make sense in that party's own terms.’ (p.26)

This is challenging in itself because it undermines the preference of some teachers to ‘locate responsibility for the problem elsewhere’ (Souter, 2001) and contradicts the fundamental attribution error of ‘within child’ or family derived behaviour difficulties. A shared understanding of the problem in the case study was never reached, which may be a main reason why the opportunity for the VEP and I to work at a systemic level within the school did not become a reality.

There are several possible explanations as to why a shared understanding of the problem was not reached; firstly the significant members of staff had differing perceptions of X's behaviour and varying success in managing her. The Deputy Head of Year taught X literacy and had a good relationship with her, rarely having to mark her down against her

targets. In contrast to this, the Head of Year, who did not teach X but met with her daily to review her behaviour record, frequently had negative interactions with her, often resulting in threats of exclusion and both parties raising their voices. The Head of Pastoral Care, who is in a senior positions to the Head of Year, managed X relatively well when she was sent to him; however this only seemed to happen in relation to the most severe incidents. Recognition that not all teachers found X difficult and therefore that some of her behaviour was related to management by staff, would mean that those particular members of staff who found X's behaviour more challenging would need to take a measure of responsibility, perhaps acknowledging a deficit in their own skills in relation to X. Such an interpretation can leave staff feeling vulnerable about their competence, which challenging pupils may have already undermined, and the staff who are more skilled at managing such pupils may feel alienated or different from their colleagues (see Section 5.3 for discussion of staff culture). Therefore a mutual punctuation point would not only mean that the school was required openly to recognise differential skill levels amongst its staff, and even 'personality clashes' between X and her Head of Year, it would also highlight a gap between the 'espoused theory' (publicly available statements of policy) in relation to management of behaviour and pupil welfare, and the theory in use (hidden staff culture and attitudes), signifying the need for systemic change.

5.3 Homeostasis, Hierarchical Organisation and Staff Culture

One reason why change did not occur in this case may be because the school system was predisposed to maintain homeostasis. Although recommendations were made by the EPS, and actions were agreed at meetings, few of these were carried out. Change in relation to the management of X's behaviour could have lead to numerous changes in other parts of

the system, such as effective use of the behaviour record by members of staff, training in consistency of behaviour management for teachers, alterations to behaviour policy and procedures and / or alterations to staff hierarchical organisation and responsibilities. Every system aims to maintain a state of equilibrium or homeostasis (see Section 2.5), and in the current case study it could be argued that X was sacrificed in order to protect this within her school. Dowling (1993) asserts that

‘schools are like many other institutional systems in their attempts to preserve equilibrium by encouraging conformity’ (p.34)

Making exceptions for X by putting into place interventions that differed from the school’s ‘normal’ procedures would involve recognising that the school’s behaviour policy and procedures do not meet the needs of every child. Members of staff present at the meetings seemed to struggle with the concept that the recommended interventions for X would mean making an ‘exception’ for her, the implication of which would be that they would have to show similar flexibility for other pupils, and would also mean that they were able to meet her needs, and those of similar young people, in their school.

Recognition of the school’s role in X’s behaviour had consequences for the hierarchical organisation of staff within the school, and indeed the current methods of managing X’s behaviour also highlighted some anomalies within the system. For example, the conflicting messages X was getting from the Head of Year and Head of Pastoral Care demonstrated differing attitudes towards exclusion, and its use as a sanction. X gave little value to her Head of Year’s warnings of exclusion because the Head of Pastoral Care made it clear that this would not happen- accentuating at the least a lack of communication, and at the most,

a lack of unity between them. In addition to this the Deputy Head of Year's skill in handling X's behaviour in comparison to her senior's efforts to do so, could make her feel defensive and incompetent in relation to X. It would seem logical that it should be the Deputy Head of Year who managed X's behaviour, and this was one of the suggestions made. However such a change is likely to disrupt the homeostasis of the system, particularly in relation to staff hierarchy and competency, which renders change less likely to happen in order to preserve equilibrium within staff relationships and roles.

A further reason why change did not occur in this case may be because of the staff culture within the school. Miller (2003) outlines the impact intervention has on other members of staff, identified through interviews with teachers carried out as part of his 'Successful Strategies' study (Miller, 1994) (see Section 5.1). In more than a third of the interviews, the teacher working with the EP was reluctant to share the information about the work they were doing in case it should upset other members of staff who had struggled to manage the pupil's behaviour previously, especially if the teacher were junior to those members of staff. Nine of the teachers also commented on the fact that although an improvement occurred in the behaviour of a 'notorious' pupil, they did not share the work they had done with other staff because their colleagues did not show any interest in the intervention or were reluctant to believe change would occur.

Miller (2003) suggests that knowledge and good practice were not shared in schools as a result of staff culture where teachers who carry out an effective intervention with a pupil or class feel they would be 'sticking their necks out' by drawing attention to this and that they may get a reputation for handling difficult pupils, and as a result be allocated the most

challenging classes. They were also worried about feeling ‘different’ and ‘isolated’ from other members of staff, even if they perceived the general atmosphere of the school as positive.

In the current case study, staff culture may have contributed to constraining the Deputy Head of Year, and the few other adults who were able positively to manage X’s behaviour, from sharing their good practice or identifying themselves as willing to work with her. During our meetings X’s Head of Year claimed to speak for all of the teachers when she said that they were feeling stressed and could no longer cope with X in their classes. If the Deputy Head of Year undermined this opinion by saying that she was able to cope, or suggesting she take over the management of X’s behaviour, this could be interpreted as her suggesting she was more capable than her senior and other staff, a consequence of which could be social and professional isolation.

6. Discussion

Galloway (1981) asserts that neither individual nor organisational work in isolation can effectively bring about change in a school;

‘assessment of organisational weaknesses which fails to account for individual idiosyncrasies, whether of teachers or pupils, is ...pointless.’ (p.168)

In the current case study, both individual and systems thinking were applied in order fully to understand the problem situation, with both adding to my comprehension of the different parties’ viewpoints. The six sessions of individual work which were carried out initially

revealed information about X's perceptions, strengths and needs; however they also highlighted the importance of the context in which the behaviours were occurring. Working at a purely individual level with X could have resulted in interventions focussed on anger management, improving literacy skills and building self-esteem, all of which have their value. However, although individual intervention may have increased X's engagement in lessons and her capacity to remain calm in response to perceived unfair treatment by teachers, the way her behaviour was managed would have remained unchanged. In the unlikely circumstance that individual intervention would be effective enough to prevent X breaking school and classroom rules again, it is likely that, as Stoker (1992) suggests, another pupil's challenging behaviour would demand the attention of school staff, and a referral to the EP.

Souter (2001) argues that systems theory provides a 'conceptual framework' which when applied to a situation, helps to explain past, and predict future behaviour. I found that in the current case study the application of systems thinking shifted the case away from a 'within child' focus, and added a richness of information to my understanding of the purpose of X's behaviour. Because X was able to reflect on her behaviour and identify her feelings, our one to one work did reveal the situations and relationships within school that caused her difficulty. However the post hoc application of key components of systems theory was useful to me in understanding the resistance to change that I and the VEP met in meetings, and provided a realistic perspective on the extent to which the school was ready or willing to change. The application of systems theory also provided a way of conceptualising and organising the complex relationships occurring within the core team of staff who managed X. It enabled hypotheses to be made concerning the reasons why the Head of Year

continued to manage X, even though their relationship had broken down, why the skills of those who were able to 'cope' with X in lessons were not drawn upon, and why there were conflicting messages concerning the exclusion of X.

Systems theory can be critiqued on a number of different levels. Silverman (1970) argues that systems theory is over simplistic in its perception of organisations and fails to consider the influence of the goals of individuals within the system. I feel that through working within the system and collecting information from the participants involved, I was able to form some hypotheses about the goals of individuals, and how these may add to the system's concern to maintain homeostasis. Unknown to myself and the VEP the Pastoral Head of Year was due to retire at the end of the school year during which our involvement took place, which could be one of the reasons why it would be beneficial to him to maintain the homeostasis of the system. An individual's goals could also be viewed as linking in with the hierarchical organisation of the system; for example the Head of Year is unlikely to action change if it highlights her inadequacies in managing the behaviour of X.

Henning-Stout and Conoley (1988) argue that the effectiveness of working at a systems level within a school is influenced by three aspects: the school history of working with previous change agents, organisational stresses, and the ideology of the school.

There are of course numerous variables relating to the skill, experience, and personal characteristics of change agents. However it is important to highlight that the VEP for the school had previously not been given the opportunity, or permission, to work at a systemic level as part of her role there (see Section 5.1). The school's 'theory in use' relating to

external agencies was that they worked through the SENCO, and were not given access to any other senior members of staff. Therefore the school had no previous experiences of consulting with EPs concerning their systems and policies.

Osborne (1994) asserts that the phenomenon of homeostasis, causing resistance to change within systems, supports a need for external change agents, such as independent psychologists. Individuals within the system often do not see the need for change because of their familiarity with the environment and patterns of action that occur within in it, and because of other competing short term demands (Argyris & Schon, 1978). If Educational Psychologists are in a better position to work as change agents within organisations, then why do we not see more of this work and the research evidence to support it (Souter, 2001)?

Stratford (2000) carried out research with 75 self-selected EPs who were invited to carry out a SWOT (strengths, weaknesses, opportunities and threats) analysis of the current role of EPs. The research found that EPs felt their ability to carry out whole school work was constrained by their service in the form of service level agreements and limited by legislative and Local Authority demands, school contextual factors and schools' perceptions of SEN as being a 'within child' phenomenon. The school context factors related to historical perceptions of the role of the EP, pressure to work with individual students, schools involving EPs in problem situations too late, when their effectiveness is limited, viewing exclusion as an acceptable strategy for managing behaviour and schools preferring 'piecemeal' change, rather than systemic change. Many of these school context factors and the perceptions relating to SEN uncovered by Stratford's research (2000) appeared to be present in the current case study, and to play a role in preventing the

systemic work which could have developed from the case. It could also be argued that the school may perceive the cost, in terms of time and effort, of making changes for one pupil too great. Although in the case study I would argue that the changes to behaviour management systems, recommended by the EPS, would affect more pupils than X alone, the school, until faced with other pupils displaying challenging behaviour, may feel that the cost outweighs the benefits.

7. Conclusions

Educational Psychologists often agree that although there is value in working individually with pupils, in order to move away from ‘within child’ models of need and that to bring about effective change, it is necessary to consider the system or organisation in which the child is located, and how this may be maintaining or causing problem behaviours. Systems thinking was used in the problem analysis in the case study, and revealed the complexity and number of interactions and relationships which were influential in X’s experience of school, as well as the opportunity for systems work within the school’s management of challenging behaviour. Whilst the application of the key components of systems theory retrospectively within this report added to my understanding of resistance to change in schools and why EPs may struggle to work at a systemic level within them.

Although the school did not act on the recommendations made by the VEP and myself, and nor did they accept our offer of support and consultation in relation to their behaviour management systems, changes in practice did take place as a result of this case. The VEP and I gained access to senior members of staff with whom we previously had no

relationship; we were able to draw attention to possible problems with the behaviour systems and policies, and make it known that we could contribute to thinking about how these could be improved. When future behaviour cases are raised, the school's VEP is now in a better position to refer to meetings and discussions held around the case study, and use these as evidence of the need for change at a systems level.

Finally, the fact that X was not excluded from school could be interpreted as evidence of either a change in the school organisation or within X. It could be that there were internal changes within the school concerning how X was managed and/or her behaviour perceived, or X's home circumstances may have changed and/or her ability to manage her own behaviour.

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Appendix 1

Summary of Work Carried Out and Meetings Attended by the Educational Psychology Service Concerning X

Individual Work

TEP worked on a one to one basis with X on six occasions, from the 13/11/07 – 09/01/08. X was raised as a concern by the school during a planning meeting on 19th September 2007 and initial meetings with Head of Year and SENCO identified the foci of the work as being:

- To help X acknowledge her behaviour and the effects it is having on others
- To gain an understanding of the influences on X's behaviour
- To prevent exclusion

Through the one to one work TEP was able to identify X's perceptions of school and home, as well as what strategies were helping her behave appropriately and those which were not, this information is summarised below.

X feels that she has a bad reputation in school with both teachers and pupils, but recognised how her behaviour may have the effect of maintaining this. She was able to identify positive reasons to change her behaviour and the possible negative outcomes if it did not change. X reported that she could distract other pupils in lessons and needed to think before responding to teachers, however she felt that teachers often did not use her behaviour report fairly and were influenced by her reputation. She also identified that she needed time to respond when teachers made requests in school, and felt that many of her interactions with staff were negative.

X often talked about the pressures she was under in her home circumstances and how she found it difficult having her young nephews living with her. She reported that she argued frequently with her mum and felt like she was used as a 'go-between' for her older siblings and mother, where their relationships had broken down. Throughout the individual work with TEP, X was punctual, polite and responsive. Between sessions 3 and 6 X reported,

and her behaviour charts recorded, an improvement in her behaviour. X felt that her friends were noticing the effort she was making, as were some teachers, and she was pleased with herself.

X found her behaviour report a useful strategy to support her behaviour in lessons. She has strong ideas about her future and possible career and finds some of her lessons enjoyable. She also reported that she found talking to someone on a regular basis about her problems useful. X identified that she found inconsistent use of her behaviour report often made her angry and could lead to arguments with teachers. She felt there was an unfair focus on her because of her previous behaviour and reputation and that some of her relationships with teachers had become very negative.

Meetings with Staff

Meetings about X's behaviour were held on three different occasions:

1. 06/02/08- attended by: SENCO, Head of Year Deputy Head of Year, Head of Pastoral Care, School's visiting Educational Psychologist (VEP) and TEP
2. 08/02/08- attended by: (as above)
3. 15/04/08- attended by: Head of Pastoral Care, TEP and VEP

Meeting One 06/02/08

Head of pastoral care opened the meeting by voicing the school's views that they felt they were unable to keep X in school because of her behaviour and the impact it was having on other children and teachers. Head of Year updated those present on X's recent behaviour incidents and the support she was currently receiving from the school which included: weekly 15 minute sessions with the BSS teacher, extra reading support, behaviour reports and regular meetings with X's mother. Head of Year reported that there was no alternative curriculum option that could be offered to X because of her age. A managed move was discussed; however the school felt that this would not work because X would be unable to sustain her behaviour.

Head of Year listed the school's concerns about X as including:

- Her safety outside of school as she appeared to be socialising with older boys
- Not working in lessons
- Preventing other pupils working
- Being abusive towards lunch time supervisors
- Not recognising the effects of her behaviour

TEP reported that X was able to talk about the effects of her behaviour on her own learning and others and took responsibility for some of it.

Head of Pastoral Care suggested the possibility of putting a reduced timetable into place to prevent exclusion, where X attended lessons taught by teachers who had positive relationships with her. Deputy Head of Year identified that she had a good relationship with X. At this point Head of Pastoral Care and Deputy Head of Year had to leave the meeting. It was agreed that a further meeting would be held and information would be collected concerning teachers who would be willing to continue to have X in their lessons.

Meeting Two 28/02/08

Head of Year opened the meeting by advising those present that a reduced timetable would not work because the geography and literacy teachers were the only ones prepared to keep X in their lessons, and these were timetabled for mornings and afternoons. This was discussed further and it was agreed that a reduced timetable should not require X to go home for mornings/afternoons, as it was unlikely that she would remain at home. Head of Pastoral Care advised that the school did not want to use a sharing panel as they felt this was just passing the problem on. TEP was able to share the work she did with X, and the pressures X felt she was under at school and home. Head of Year confirmed that often X requested to leave school early in order to pick up her nephews.

TEP suggested X may respond to:

- Regular mentoring from someone she relates to

- A course/project based in school or out of school which provides her with work experience opportunities
- Involvement in PE clubs or lessons
- Consistent use of her behaviour record/chart

Head of Pastoral Care asked if there were any suggestions TEP or VEP could make to help teachers manage X. This was confirmed and TEP suggested that there may be some suggestions relevant to whole school behaviour policy as well. It was agreed that TEP and VEP would meet with Head of Pastoral Care to discuss behaviour at a systemic level in school. SENCO took away X's timetable to see how it could be reduced and agreed to contact Targeted Family Support. TEP agreed to look into Youth Inclusion Support Team.

Meeting Three: 15/04/08

At the beginning of this meeting Head of Pastoral Care confirmed that X was still on a full time timetable and that her behaviour report was not in use because X had covered it with stickers and some of the staff felt she was not using it appropriately. TEP and VEP informed Head of Pastoral Care about positive and negative aspects of the school's behaviour system that had become apparent through working with X. These were discussed in detail in reference to X and other pupils who may have behavioural problems. The VEP also talked through a possible method of using a reduced timetable with the aim of integrating X back into her lessons.

TEP and VEP were able to offer the school:

- Behaviour training/ input for school management/ teachers in September 2008 if this was required (school to request from EP if they would like this training).
- Continued support for X on a fortnightly basis in the form of meeting with TEP to discuss school and home, with a view to review at the end of summer term (to date this has not yet been requested by the school).
- A summary of the progressive reduced timetable discussed in the meeting

CHAPTER FIVE

PARENTS' PERSPECTIVES ON ADHD, ITS DIAGNOSIS, TREATMENT AND THE DEBATE SURROUNDING IT: A REVIEW OF THE LITERATURE WITH REFERENCE TO TWO CASE STUDIES.

PARENTS' PERSPECTIVES ON ADHD, ITS DIAGNOSIS,
TREATMENT AND THE DEBATE SURROUNDING IT: A REVIEW
OF THE LITERATURE WITH REFERENCE TO TWO CASE
STUDIES.

Abstract

Within the context of frequent media coverage and continuing debate amongst professionals about ADHD, this professional practice report reviews current literature on the nature of ADHD as a disorder, and parental perceptions of it. The contrasting views on ADHD are summarised in addition to literature on the symptoms and causes of ADHD, comorbidity with other disorders, epidemiology, assessment and diagnosis procedures, and treatment. Research on parental understanding of ADHD; how parents perceive the disorder, how it affects their own emotional well-being and family functioning, and their experiences of diagnosis and treatment is reviewed. Vignettes from two case studies of children with ADHD attending primary schools in a West Midlands Local Authority, with whom the Trainee Educational Psychologist worked, are presented. These case studies are referred to when considering the EP's role in working with parents of children with ADHD, the schools they attend, and in contributing to the diagnostic and treatment procedures. This report concludes by emphasising the importance of EPs putting aside their personal views in relation to ADHD, and presenting a bio-psychosocial account of ADHD that recognises the value of multi-modal assessment and treatment, without adding to the distress and frustration many parents experience, caused by the dichotomous views commonly held by differing professionals.

PARENTS' PERSPECTIVES ON ADHD, ITS DIAGNOSIS,
TREATMENT AND THE DEBATE SURROUNDING IT: A REVIEW
OF THE LITERATURE WITH REFERENCE TO TWO CASE
STUDIES.

1. An Introduction to ADHD: Summary of Present Thinking and Research Literature Relating to ADHD as a Disorder; its Aetiology and Epidemiology.

Attention Deficit Hyperactivity Disorder (ADHD), described as 'the Diagnosis du Jour' (Bogas, 1997), is one of the most commonly diagnosed (Barkley, 2005) and intensively researched neurodevelopmental disorders of today (American Psychiatric Association, 2000). However it is also a disorder that remains surrounded by controversy as professionals continue to debate the ambiguity of its core symptoms, methods of diagnosis, and treatment using psychostimulants (Hinton & Wolpert, 1998). Whilst working in a range of different schools as a Trainee Educational Psychologist (TEP), I have heard the term 'ADHD' used frequently, and often with little evident understanding, by school staff and professionals working for Local Authority Children's Services. I have also had my views on ADHD challenged through multi-agency working and interactions with parents, amongst whom there are also disparate understandings of this disorder.

Norris and Lloyd (2000) ask,

‘What factors are present that allow the condition [ADHD] to be taken up so enthusiastically by some, yet condemned wholeheartedly by others?’ (p.124)

Researchers argue that, as a diagnosis, ADHD only describes the behaviours or symptoms present in those who are identified as having it, without providing information about its aetiology or what causes these behaviours (Hinton & Wolpert, 1998). It is also criticised because diagnosis requires a judgement of what is ‘normal’ behaviour and what is judged to be ‘pathological’: a decision which is subjective and heavily influenced by social culture (Singh, 2008). Others purport that ADHD is controversial because of the increasing use of psychostimulants to treat it (Multimodal Treatment Study of ADHD (MTA) Cooperative Group, 2004) and because there is no scientific consensus about how these drugs, such as Methylphenidate, act on the brain to change behaviour (Singh, 2004). Further accusations in relation to the prescription of medication assert that, although drug treatment is appropriate for some children, medication is often prescribed too readily, with minimal monitoring, to children with a range of behavioural problems (Baldwin, 2000).

Hinton and Wolpert (1998) argue that ‘organic accounts’ of ADHD are favoured amongst parents because they provide an explanation for their child’s behaviour, whilst acquitting their parenting skills from any blame. They also suggest that teachers may perceive a diagnosis of ADHD as alleviating their responsibilities in relation to such children’s learning and management of their behaviour in the classroom. In response to these views, research suggest that parents often feel ‘blamed’ for their child’s behaviour, and find the

conflicting opinions on ADHD held by professionals both confusing and stressful (Harborne et al, 2004) (see Sections 3.1 and 3.3 for further details).

While debates continue in professional and educational domains, media attention has fuelled public interest in ADHD, often with dramatic headlines ‘regardless of the vigour with which researchers stress a cautionary stance’ (Reid & Maag, 1997, p. 12). Such coverage could be argued to fuel teacher and parental awareness of ADHD, making them more likely to advocate it as a diagnosis in children with other behavioural problems, whilst also confirming perceptions that it is necessary to ‘fight’ with professionals in order to receive a diagnosis and medication (Norris & Lloyd, 2000).

All of the main opinions and beliefs surrounding ADHD, outlined above, risk acting to polarise people’s perceptions of the disorder, resulting in definite disparities in conceptualisation, commented on by Norris and Lloyd (2000), and recognised widely throughout research and media coverage. This professional practice report has three main objectives:

1. to summarise present thinking and research literature relating to ADHD as a disorder; its aetiology, epidemiology, assessment, diagnosis and treatment, in order to gain an understanding of the divergent constructs surrounding it (Sections 1 & 2);
2. to review the literature on parents’ perceptions of ADHD, how it affects their family life and relationships, and their experiences of diagnosis and treatment (Section 3); and

3. to use two case study vignettes where children had been ‘identified’ as having ADHD, to consider EP practice when working with parents, schools and other professionals, with reference to current thinking about ADHD (Sections 1 & 2) and research on parental understanding of ADHD (Section 3).

1.1 The Presentation/ Symptoms of ADHD in Children and Young People

The DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders- 4th Edition) (APA, 2000) groups the 18 symptoms related to ADHD under two headings: Inattention and Hyperactivity-Impulsivity, with nine symptoms in each group (see Appendix 1 for full DSM-IV criteria). It states that symptoms must have ‘persisted for at least six months to a degree that is maladaptive and inconsistent with the child’s developmental level (APA, 2000) and asserts that some symptoms must have been present before the age of 7 years, and should be exhibited in two or more settings and not be due to another psychiatric disorder. ADHD is often behaviourally evident as a loss of self-control, poor self-regulation, distractibility and a deficit in inhibitory control (Carroll et al, 2005).

There are three subtypes of ADHD: combined type (ADHD-CT), predominantly inattentive types (ADHD-IA), and predominantly hyperactive-impulsive type (ADHD-HI); the criteria for diagnosis of each are outlined in Table 1 (DuPaul & Stoner, 2003). The DSM-IV- TR (APA, 2000) criteria for the diagnosis of ADHD means that children with this disorder are a heterogeneous group and can exhibit a wide range of different combinations of symptoms, making identification of causal factors and long-term

outcomes difficult. As a result of this research has focussed on finding more homogenous subtypes of ADHD (DuPaul & Stoner, 2003).

Table 1- Subtypes of ADHD and Symptoms Exhibited (adapted from DuPaul & Stoner, 2003)

Subtype of ADHD	Diagnostic criteria in DSM-IV- TR (APA, 2000) and research evidence of differences
ADHD combined type (CT)	<p>Display at least 6 of the 9 inattentive symptoms and at least 6 of the 9 hyperactive-impulsive symptoms</p> <ul style="list-style-type: none"> • Show higher rates of impulsivity, over-activity, aggression, non-compliance and peer rejection (Carlson & Mann, 2000) • More likely to be diagnosed with other behaviour disorders (Barkley et al, 1990) (See Section 1.4)
ADHD predominantly inattentive type (IA)	<p>Exhibit at least 6 of the 9 inattentive symptoms, but fewer than 6 of the hyperactive-impulsive symptoms</p> <ul style="list-style-type: none"> • May have greater problems with memory retrieval (Barkley et al, 1990) • Described as ‘slower’ cognitively and more withdrawn from other children (McBurnett et al, 2001)
ADHD predominantly hyperactive impulsive type (HI)	<p>Exhibit at least 6 of the 9 hyperactive-impulsive symptoms, but fewer than 6 of the inattentive symptoms.</p> <ul style="list-style-type: none"> • Little research but some evidence suggests this is more prevalent in pre-school children and may be a pre-cursor to ADHD-CT (Lahey et al, 1994)

In addition to its three different subtypes, ADHD can also be present with aggression (externalising disorders) or internalising disorders. Often children with ADHD and

aggression are also diagnosed as having Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD), because of the co-morbidity between them (DuPaul & Stoner, 2003).

Research suggests that children with ADHD and aggression display higher levels of antisocial behaviours than those who have ADHD alone (Barkley, 2005). They also have poorer outcomes in adolescence and adulthood (Jensen et al, 1997). Children with ADHD and internalising problems are more likely to be socially withdrawn and have problems forming relationships with their peers (Buhs & Ladd, 2001). However internalising problems have been suggested to be a protective factor, because when they are present hyperactive-impulsive behaviours are less severe and co-morbid disorders, such as CD and ODD are less likely to occur (Pliszka et al, 1999).

Although the DSM-IV (APA, 2000) diagnostic criteria is most commonly referred to within the research reviewed in this report, perhaps highlighting that the majority of the research is carried out within the United States, the diagnostic criteria generally used within Europe is the International Classification of Diseases-10 (World Health Organisation, 1993). The ICD-10 (WHO, 1990) uses the term Hyperkinetic Disorder as opposed to ADHD, however its criteria is very similar to the DSM-IV (APA, 2000) with the exception that the latter allows multiple diagnoses with co-morbid conditions, for example ADHD with Conduct disorder, whilst the ICD-10 has a separate diagnosis of Hyperkinetic Conduct Disorder (Moffitt & Melchior, 2007).

1.2 Theories on the Causes of ADHD

Cooper (2001) asserts that although ADHD is one of the most widely researched disorders there is still no consensus on what causes it. Neuro-biological and genetic theories have been proposed and find some support within genetic and neuro-imaging research (Cooper, 2001); however DuPaul and Stoner (2003) warn against making causal links with identified variables in correlational research. Barkley (2005) suggests that a number of causal mechanisms may produce ADHD symptomatology. These theories, along with a bio-psychological perspective (Frith, 1992) are summarised in Table Two.

Singh (2001) describes the main conflicting approaches to understanding the causes of ADHD as ‘mother-blame’ and ‘brain-blame’, illustrating the extreme differences between medical and social models of aetiology. She suggests that often professionals either allocate responsibility for ADHD, or behaviour identified as ADHD, to parenting practice, particularly that of mothers, or to biological dysfunction, thus removing the causes of problem behaviours ‘out of the social realm and into the individual brain’ p.1194. Cooper (2001) suggests that whilst the biological effects on ADHD, heavily implicated by research, are still being investigated it is necessary to recognise psycho-social influences, which are closely interwoven.

In his argument for a bio-psycho-social approach to understanding ADHD Cooper (1997) suggests that ‘dangerous dichotomies’ such as the belief that challenging behaviour is either socially constructed or a product of within child factors, and that these theories are mutually exclusive, can delay the ‘development of effective responses to ADHD’ (p.34) leading to poor outcomes for children. Cooper (1997) offers four reasons why a bio-

psycho-social approach to ADHD should be adopted: firstly he asserts that a biological disposition towards developing ADHD does not mean that this will occur; emotional and behavioural needs are influenced by additional individual, political and social factors. Secondly a combination of medical and educational approaches to intervention are likely to be more powerful than one of these in isolation. This is supported by recent NICE guidelines (2008b) which assert that medication should not be used in isolation. Thirdly an effective bio-psycho-social approach to intervention will require different professionals work together and adopt a joined up approach when supporting a child; benefiting medical professionals who have little experience of the educational system. Finally Cooper (1997) argues that a diagnosis of ADHD can lead to positive outcomes for some children, providing access to support groups and different treatment options.

Table 2- Theories of the Causes of ADHD

Theory	Research evidence to support it
Neurobiological	<ul style="list-style-type: none"> • The pre-frontal cortex of the brain has been investigated because many of the symptoms of ADHD are similar to those seen in people with brain injury in this area, believed to be involved in the inhibition of behaviour and mediation of responses to environmental stimuli (DuPaul & Stoner, 2003). • Structural differences found in the fronto-striatal networks of the brain in children with ADHD using Magnetic Resonance Imaging, and in the way it functions using Positron Emission Tomography (Tannock, 1998). • Some neurotransmitters have also been found to be less available in certain areas of the brain (Tannock, 1998).
Genetic	<ul style="list-style-type: none"> • There is ‘consistent’ evidence that ADHD may run in families (Faraone, 2000). • ADHD is more common in the biological relatives of children with ADHD than in the relative of children without ADHD (Levy & Hay, 2001). • Studies with identical twins have shown that if one has ADHD the chances of their twin having it are significantly higher than non-identical twins (Levy et al, 1997). • Molecular genetic studies have found differences in the dopamine receptor and transporter genes (Levy & Hay, 2001).
Environmental toxins	<ul style="list-style-type: none"> • A number of environmental toxins have been investigated in relation to ADHD, including nutrition (sugar and preservatives/e-numbers), lead poisoning and prenatal exposure to drugs or alcohol (Barkley, 2005). • Controlled studies investigating the effects of sugar and food additives have shown that dietary factors play no

	significant role in ADHD (Barkley, 2005).
Bio- psychosocial	<ul style="list-style-type: none"> • The above theories are based on ‘within child’ explanations, which Cooper (2001) suggests is a limitation of current research. • Researchers argue it is necessary to understand ADHD as a biopsychosocial problem because although there is evidence indicating biological factors have an important role the ‘precise nature of the association between neurology, cognition and behaviour’ in ADHD is unknown (Baldwin & Cooper, 2000, p.599). • Frith (1992) argues for a biopsychosocial approach which challenges the nature Vs nurture debate by arguing that the extent to which neurological problems affect behaviour and cause social dysfunction is mediated by the individual’s learning and experience.

1.3 ADHD and Comorbid Disorders

Research on ADHD recognises that one of the factors that complicates the diagnosis and intervention process is its high level of comorbidity with other disorders such as conduct disorder (CD) in children and personality disorder in adults (NICE, 2008a). As many as 75% of children with ADHD are thought to meet the criteria for another psychiatric diagnosis because of an overlap of symptoms; for example, inattention may be evident in anxiety and depression, whilst non-compliance is present in conduct disorder and oppositional defiant disorder (ODD) (Barkley, 2005). The most common co-diagnosis with ADHD is ODD, with over 40% of children and 65% of teenagers with ADHD displaying significant ODD related behaviours, whilst one quarter to a half of children with ADHD are thought to meet the criteria for depressive and anxiety disorders (Jensen et al, 1997). This overlap of symptoms and the 'subjective process', based on a clinician's judgement, leading to a diagnosis (see Section 2.1) increases the likelihood of an incorrect diagnosis of ADHD (Reid &Maag, 1997).

1.4 Epidemiology of ADHD

Epidemiological studies have produced varied findings in relation to the number of children and adults diagnosed with ADHD. It is thought that in America 7% of children aged between six and 11 years have been diagnosed with ADHD (Centers for Disease Control and Prevention Report (CDC), 2002) and that in 2001 approximately 3% of American children were taking methylphenidate for ADHD, (Cooper, 2001). There are significant variations in national prevalence rates of ADHD and use of methylphenidate as a treatment. Although this is recognised in the research, little analysis has been carried out to determine the extent of differences and possible causes (Singh, 2008). Some research

suggests that international prevalence rates vary between 3-6% of school aged children and young people (Cooper, 2001), with approximately 75% of referrals being boys (CDC, 2002).

An additional complexity in determining the prevalence of ADHD is that fact that reliable rates of diagnosis are rare in most countries, often leading to judgements relating to increases in diagnosis being based upon methylphenidate use (Singh, 2008). America is thought to currently use 80% of the world's methylphenidate for medical reasons (United Nations International Narcotics Control Board, 2005) its consumption having increased 6-fold in the decade from 1989-1999 (UNINCB, 1999), in line with many other countries which have seen a 5-7 fold increase (Singh, 2008). Methylphenidate consumption is argued to be a reliable indicator of ADHD prevalence because the United Nations Narcotics Control Board keeps records of its production and consumption; it is rarely prescribed for medical conditions other than ADHD and illegal consumption for recreational purposes is not believed to be significant enough to be considered separately (Singh, 2008). However methylphenidate is not the only treatment for ADHD; prescribing of amphetamines increased more than 2000% between 1991 and 1999 (UNINCB, 1999), although the extent to which this is due to increased prescriptions to treat ADHD is unknown. In addition to those treated with drugs it is necessary to consider the minority of children and young people diagnosed with ADHD who are not medicated.

Sciutto and Eisenberg (2007), when discussing public, media and often professional perceptions that ADHD is over-diagnosed, argues that prevalence rates vary greatly depending on the assessment methods used by epidemiological studies and the age of the

participants. For example prevalence rates have been found to be within the 3-7% estimated by the DSM-IV-TR criteria (APA, 2000) with children aged four to eight years, but slightly higher for those aged nine to 17 years (Center for Disease Control and Prevention, 2005). Sciutto and Eisenberg (2007) reviewed 14 studies and found that those which used random sampling methods and had larger samples were more likely to find prevalence rates lower within the 3-7% range, whilst those studies using non-random sampling, screening measures and/or relying on one source of information only often reported prevalence rates higher than that predicted by the DSM-IV TR (APA, 2000). Where prevalence rates are based on figures detailing access to medical treatment and intervention, these fail to consider the 50% of children with mental health needs who do not receive any form of treatment (Kataoka, 2002), a factor which is influenced by gender, age, ethnicity, culture and health insurance (in the countries where this applies) (Power et al, 2005).

It is clear that there is mixed evidence relating to the epidemiology of ADHD and this will continue to be subject to questions and criticism whilst there is no consensus on a criteria for, or method by which, cases of ADHD are recorded nationally and internationally. Although some studies report an increase in the consumption of methylphenidate, it is over simplistic to assume a cause and effect relationship between this and the diagnosis of ADHD. Sciutto and Eisenberg (2007) emphasise the importance of the sampling methods and inclusion criteria used, both of which may be undermined by the high rate of comorbidity with other disorders (see Section 1.4) and varying practices in relation to the diagnosis of ADHD (see Section 2.1).

2. The Diagnosis and Treatment of ADHD: A Summary of Current Research Literature

2.1 Diagnosis of ADHD

NICE ADHD guidelines (2008a) recommend to parents the route to diagnosis outlined in Figure 1; however my experience of working in three different Local Authorities has been of varying protocols, from lone GP to multi-agency diagnosis and management of medication. NICE guidelines (2008a) advise

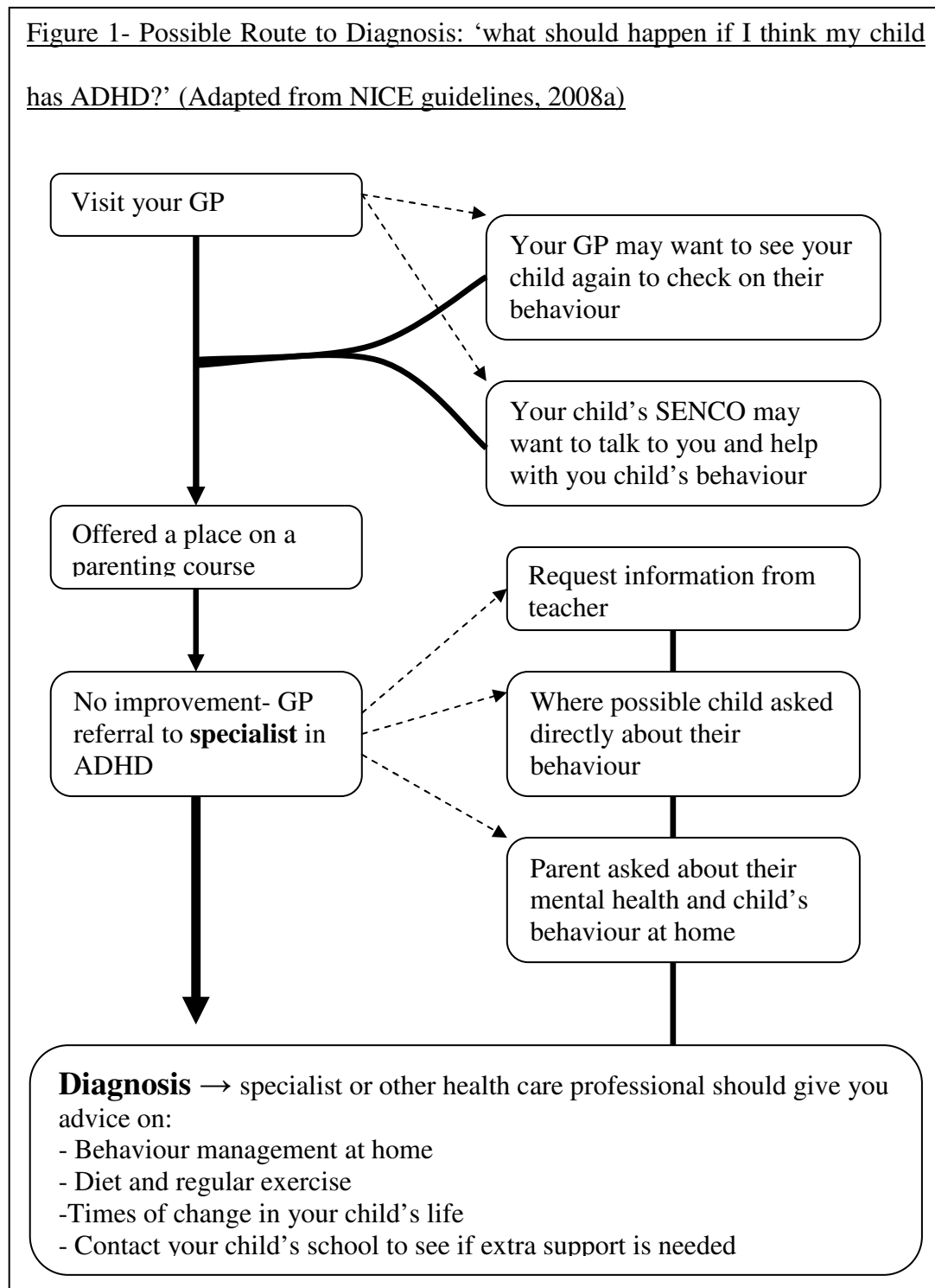
‘your child should only formally be diagnosed with ADHD by a specialist, who should first assess your child’ (p.5),

and assert that this specialist could be a paediatrician, child psychiatrist, or another professional with specialist experience in ADHD, such as an occupational therapist or learning disability specialist. Literature suggests that professionals involved in the diagnosis of ADHD agree that best practice should involve the clinician adopting a multi-method approach, where multiple sources and different settings are considered to gain information about the child’s symptoms, the contexts in which they are most/least evident, their persistence, frequency, intensity and the severity of the impairment they cause, with reference to standardised diagnostic criteria, such as the DSM-IV TR (American Academy of Paediatrics, 2000).

DuPaul and Stoner (2003) recommend assessment methods should include: clinical interviews with the child, parent and teacher; standardised behaviour rating scales completed by the parent and teacher, such as the Connors Rating Scales Revised-Short

Form (Conners, 1997); and review of school records/information and observation of the child's behaviour, ideally in the classroom and less structured situations.

Figure 1- Possible Route to Diagnosis: 'what should happen if I think my child has ADHD?' (Adapted from NICE guidelines, 2008a)



When considering which professional is best placed to make the diagnosis The British Psychological Society (BPS) (2000) is in agreement with NICE guidelines (2008a) in recommending that a specialist in ADHD, such as a child psychiatrist or paediatrician should ‘normally’ make the formal diagnosis; however it does assert that diagnosis should be based on a multimodal assessment involving professionals from a range of disciplines, ideally a teacher, health visitor, psychologist and physician, in consultation with the parent and child.

Although ‘best practice’ in the diagnosis of ADHD appears to be non-contentious amongst professionals, it is recognised that actual practice varies widely, with disparate frequencies of diagnosis among different practitioners (NIH, 1998). A number of possible factors have been identified as causing these differences including ADHD’s comorbidity with other disorders (see Section 1.4), diagnostic inaccuracy and varying practice, and changes in diagnostic criteria (Sciutto & Eisenberg, 2007). Research carried out with clinical, counselling and school psychologists found that only 15% used multiple methods of assessment consistent with recommended standards, and diagnosis of ADHD was influenced by the type of psychologist involved and the setting in which assessment took place (Handler & DuPaul, 2005). Baldwin and Cooper (2000) assert that in the UK some children have been given a ‘blind diagnosis’ by professionals, over the phone or via the internet, without even the completion of a clinical interview.

There is some evidence to suggest that the diagnostic criteria used in the assessment of ADHD may be influential in whether a label of ADHD is formally given or not. Wolraich et al (1996) compared the DSM-III-R diagnostic criteria with the updated version, DSM-IV

(APA, 1994), and concluded that the newer criteria may result in an increase in diagnoses, thought to be caused by the addition of subtypes of ADHD (Barkley, 2005). The BPS (2000) comments on the similarity between the DSM-IV (APA, 1994) description of ADHD and the World Health Organisation's description of Hyperkinetic Disorder used in the International Classification of Diseases (ICD-10) (WHO, 1990) and argues that the few differences between the two criteria result in DSM-IV being more inclusive, thus leading to higher prevalence rates.

2.2 Treatment of ADHD

The use of stimulant drugs to treat children with behavioural difficulties dates back to 1937, when Charles Bradley published accounts of experiments he carried out with 30 children which produced marked improvements in their academic work, motivation and emotional state (Bradley, 1937, cited in Singh, 2008). Currently psychotropic medication is the most common treatment for ADHD (DuPaul & Stoner, 2003); the increase in consumption of methylphenidate and amphetamines over the past decade is documented in Section 1.5 of this report. More than 4% (1.5 million) of school-aged children in the US are treated with medication such as methylphenidate (also known as Concerta and Ritalin), with the average duration of use ranging from two to seven years, depending on the age of the child (Safer & Zito, 2000).

Psychotropic medications, of which methylphenidate is one, are central nervous system stimulants, acting to increase arousal or 'alertness' (DuPaul & Stoner, 2003). The main effects claimed for such medication include a rapid improvement in attention and impulse control for approximately 70-75% of school-aged children after one or more doses

(Rapport & Denney, 2000). The remaining 25-30% of children will either see no improvement or their symptoms may worsen, indicating the need for different drug treatment or alternative intervention (DuPaul & Stoner, 2003). The efficacy of drug treatment in suppressing the symptomatology of ADHD is widely recognised (Wright, 1997; Lord & Paisley, 2000; Barkley, 2002); however so are the similar effects these drugs would have on children and young people without ADHD (Rapport et al, 1980).

Atomoxetine (Strattera) is a relatively new nonstimulant treatment that has been approved for use with adolescents with ADHD (Wolraich et al, 2005). The drug is yet to be extensively researched (DuPaul & Stoner, 2003); however it is thought to be similar in its efficacy and tolerability to stimulant medications, with fewer short term effects on growth in height and weight (Michelson et al, 2002). Although atomoxetine is recognised to have side effects such as sedation, appetite suppression, nausea and headaches, it has no abuse potential and is not listed by the Drug Enforcement Administration (Wolraich et al, 2005). DuPaul and Stoner (2003) assert that further research is needed into the use and effects of atomoxetine; however it may have the potential to treat children who do not respond to stimulants.

The perceived advantages and disadvantages of drug treatment for ADHD are outlined in Table 3, and also include specific consideration of the prescription of stimulant medication to children under the age of 6 years old, and the use of high doses, both of which are not recommended by the drug companies themselves (Baldwin & Cooper, 2000). NICE guidance (2008b) asserts that drug treatment should not be used for pre-school children or as a first-line treatment for school-age and young people with moderate ADHD. Instead it

suggests that parents should be initially referred to a parent training/ education programme if they have not been to one before or if it was only partially effective. Interventions suggested for children or young persons themselves include cognitive behaviour therapy and/or social skills training either individually or as part of a group (NICE, 2008b).

Anti-drug treatment researchers argue that Methylphenidate has become so popular because of the relative ease and speed with which it calms children's behaviour (Jacobs, 2002, cited in Tait, 2005). Taylor et al (2006) cite the 2004 Western Australian Education and Health Standing Committee's report on the status of ADHD in Western Australian, when reflecting on drug treatment as an easy option in comparison with psychosocial interventions. The report identifies that medication is cheaper than other options because the most common drugs have been placed on a Pharmaceutical Benefits Scheme, and there is limited availability of multidisciplinary professional teams to carry out alternative or multimodal interventions. During the two years I have worked as a Trainee Educational Psychologist I have supported educational and behavioural interventions within school for children with ADHD; however I have rarely been aware of ongoing multimodal assessment or intervention by other agencies.

Table 3: The Advantages and Disadvantages of Drug Treatment for ADHD in Childhood and Adolescence

Disadvantages/ criticisms of drug treatment	Advantages/ responses to criticisms of drug treatment
<ul style="list-style-type: none"> • Methods used in research which supports drug treatments are flawed e.g. no use of randomised controlled trials. Some research has been funded by the drug industry (Baldwin & Cooper, 2000) • Methylphenidate is a member of the amphetamine family & is regulated worldwide because of abuse potential (Singh, 2008). Moline & Frankenberger (2001) found 34% of high school students taking medication had been approached to sell it. • Adverse drug reactions include agitation, tics, Tourettes, depression, stomach ache, diarrhoea, weight loss, growth suppression, chest pains, and headaches (Baldwin, 2000). • Research suggests that academic performance is not significantly improved by use of stimulant medication & behavioural improvements may only last as long as medication is taken (Lord & Paisley, 2000). • It is widely agreed that medication alone is not a sufficient treatment for ADHD (NICE, 2000; BPS, 2000). 	<ul style="list-style-type: none"> • Reviews of studies on the benefits of medication have reported more acceptable behaviour at school and home, improvements in family life & more engagement in academic work (Lord & Paisley, 2000). • Methylphenidate, although recognised to be one of a group of substances with abuse potential is thought to be non-addictive (Cooper, 2001). Stahl (2000) reports that patients show little or no tolerance to the drug or the need for escalating doses or withdrawal symptoms. • The majority of users only suffer mild side effects which can be avoided or lessened through careful adjustment of dosage & attention to routine (Cooper, 2001). • Research shows that medication improves attention, concentration & productivity in school (Evans et al, 2000). • Medication should be part of a multimodal intervention approach, using behavioural, pro-social, cognitive and environmental intervention (BPS, 2000; NICE, 2000).

Those in favour of multimodal intervention argue that its main purpose is to increase parents' and children's understanding of ADHD and how to manage it, something which drug treatment in isolation will not do (BPS, 2000). Cooper (2001) states that multimodal intervention allows ADHD to be seen not only as a 'within child' problem, but also as a 'dysfunction' created and influenced by the environment in which the individual exists. This allows parents and teachers to understand that the child's behaviour is not deliberate or a problem of motivation, and facilitates helpful thinking concerning how the environment can be changed to support the needs of the young person.

The BPS (2000) argue for a principle of minimal invasiveness when treating ADHD,

'attention to aspects such as behavioural management and educational practice should precede efforts to 'change' a child. Ecological and systemic interventions, social competence training, behavioural and cognitive interventions should precede, and continue during medication.' (p.15)

However some ADHD researchers argue that alternative treatments to drug intervention are ineffectual (DuPaul & Stoner, 2003).

It would appear that contrasting opinions on the use of drug treatment for ADHD, similar to disparate understandings of the causes of ADHD, are unhelpful, with evidence in support of both sides amongst the vast body of literature on this disorder. Although there is recognised best practice in diagnosis, highlighting the importance of multi-agency assessment and contribution, and NICE guidance (2008b) on the treatment of ADHD, it would seem that differing practice still occurs and disparate views are held by professionals. Within the following section I will review the research on parent's

understanding and experience of ADHD, in particular how they contribute to its diagnosis, how they perceive choices in its treatment, and how they perceive it to affects family life.

3. Parents and ADHD: Parents' Perceptions of ADHD, how it Affects their Family Life and Relationships and their Experiences of Diagnosis and Treatment.

Although a seemingly obvious assertion, Hoza et al (2000) emphasise the vital role of parents, both legally and functionally, in the behavioural and psychological outcomes of their children. Parents, along with teachers, are responsible for monitoring the development of their children, and seeking help or assessment should this be perceived to be a cause for concern. Similarly children rely on their parents for implementation of interventions, both medical and behavioural/social, and continued monitoring and judgement as to whether these have been successful. Therefore it can be assumed that parents' understanding of their child's disorder and possible treatments, their perceptions of their role in the process and of themselves as parents, are likely to influence the type of assessment and intervention sought, and its success (Klasen & Goodman, 2000). In the case of ADHD, where media attention highlights the dichotomous arguments surrounding its causes and treatment, and the role of parenting in this, (see discussion in Section 1.1) it could be hypothesised that parents are more likely to enter into the process of assessment and treatment with preconceived ideas and opinions. The following sections explore the literature on parents' understanding of ADHD, the assessment and diagnostic procedure, treatment options available to them and how ADHD affects their family life, with reference to two case studies.

3.1 Parental Understanding of ADHD

The majority of research suggests that parents often perceive ADHD to be biologically-based disorder (Klasen & Goodman, 2000; Norris & Lloyd, 2000; Harborne et al, 2004; Travell & Visser, 2006). Klasen and Goodman (2003) carried out semi-structured interviews with parents (n=29; 19=mother only, 9=parents together and 1=parents separately) and GPs (n=10) in London, England to determine what views they held about hyperactivity and the extent to which there is agreement between them. A purposeful sampling method was used to recruit parents with varied views and experiences in relation to ADHD, including those from a tertiary psychiatric referral clinic, a support group focussing on complementary medicine and diet, community services, the private sector and a parent support group with a bio-medical focus. The 'formal inclusion criterion' was parents' belief that their child had ADHD; however for 24 of the 29 this had been confirmed by a medical specialist. A grounded hermeneutic approach was used to analyse the data and identify the following questions: is hyperactivity a medical disorder; is labelling helpful and; is hyperactivity a result of family dysfunction?

Independent of which group/clinic parents were recruited from they described hyperactivity as a medical problem. Parents attending the alternative support group perceived ADHD as apart of a wider medical problem linked with allergies, diet and vulnerability to infection, whilst parents from the psychiatric clinic emphasised chemical imbalance in the brain,

'It's a chemical imbalance; it's this dopamine that is missing; his body doesn't make enough of it. It's like with diabetes, its genetic.' (p. 200)

In contrast to this GPs were unsure of the boundaries between acceptable behaviour and abnormal behaviour and were aware that this boundary is affected by cultural and social variation. Only two of the GPs held strong views that hyperactivity was a medical disorder and in both cases this was related to experiences of family and friends' children being diagnosed with ADHD. GPs emphasised the role of the family and parenting in the cause and management of hyperactivity, whilst parents indicated that family dysfunction was a result of the child's behaviour problems (Klasen & Goodman, 2000).

Harborne et al (2004) carried out semi-structured interviews with the mothers and one father of nine boys diagnosed with ADHD, aged between eight and 11 years, within a town in Bedfordshire. Again a grounded theory approach was used to explore parents' understanding of ADHD and the extent to which they were aware of the differing views on its causes. Results indicated that mothers felt blamed for their child's behaviour, and that they felt others viewed it as a product of 'bad parenting'. In contrast to this, parents themselves viewed their child's difficulties as the result of an 'innate biological condition' (p.331). However five of the mothers allocated some blame to themselves, querying the relevance of a number of factors such as their returning to work too early, having children too close together, or a genetic problem, and four related their child's problems to those experienced by their husbands (Harborne et al, 2004).

Bussing et al (2003) carried out research in the US to explore parents' (n=182) explanatory models of the cause of ADHD using a semi-structured, open-ended questions. Children were included in the study if parental interviews identified that they either had a diagnosis of ADHD, parents or teachers had voiced a concern about them possible having ADHD, or

if the child had elevated scores on a standardised checklist for ADHD. They found contrasting results to the previous two studies, with the majority of parents referring to their child's disorder using a general 'problem' label, and only a third using a medical term. However, similar to Klasen and Goodman's study (2003) parents whose children were on medication were more likely to use medical language to describe their child's needs. Differences were also evident depending on parents' socio-economic status, with those with higher socio-economic status being more likely to use general terms to describe ADHD, rather than medical terms. Mixed results were found concerning parents' understanding of what causes ADHD; over one quarter of parents were not able to suggest a cause for their child's ADHD and a quarter identified stressful life events or genetic influences. 17% of parents linked the identification of ADHD with their child starting in the more structured environment of school and parents of boys were more likely to associate the onset of ADHD with genetic causes rather than stressful life events (Bussing et al, 2003).

3.2 Effects of ADHD on Family Life and Relationships

Many research papers document the detrimental effects that living with a child with ADHD has on family life and relationships (e.g. Whalen et al, 2006; Kopley, 2007). For parents these include decreased feelings of parental competence, efficacy and satisfaction and increased caretaking demands, family discord and feelings of stress and blame (Bugental & Johnston, 2000). Klasen & Goodman (2000) assert that parents report feeling tired, depressed, anxious and angry, with marital problems often caused by blaming each other or disagreements over how to manage their child's behaviour.

Whalen et al (2006) argue that the negative influences of ADHD on family life are not just ‘side effects’, they can act to determine the developmental course of ADHD and its long-term outcomes by influencing the ‘emotional climate’ in the child’s home, the parents’ resilience and the quality of relationships. Barkley (2005) suggests that family factors may be salient in contributing to secondary difficulties in children with ADHD, including comorbidity. ADHD also affects parent’s cognitions and interpretations of their child’s behaviour: specifically what causes the behaviour and the extent to which it is controllable (Bugental & Johnston, 2000). Both of the above factors can act to shape negative interactions between the parent and child, which in turn impact on the home environment and parental cognitions, forming a circle of reciprocal interactions. Finally it is important to recognise the high comorbidity of ADHD with other behavioural disorders, such as Conduct Disorder, and the additional impact these may have on behaviour and relationships at home (see Section 1.4).

3.2.1 Mothers and ADHD

Singh (2004) argues that mothers are over-represented in research on ADHD, reinforcing feelings of blame which they commonly report. Singh (2004) suggests that although studies refer to parents and children with ADHD, the majority of the time this alludes to ‘mothers and their sons’, a suggestion supported by much of the literature referenced in this professional practice report. The extent to which this observation is due to availability of mothers, in comparison with fathers, to take part in research, and the higher prevalence of ADHD amongst boys (CDC, 2000) or to the ‘mothering ideology’ created by our culture, as suggested by Singh (2004) is unclear. However, such a focus leads to the claim that

‘mothers stand to benefit most from whatever absolution comes with a medical answer and solution to children’s problem behaviors.’ (Singh, 2004, p.1194)

Harborne et al (2004) found that the nine mothers they interviewed felt blamed by a number of different sources, including teachers at their child’s school, their own families, particularly their mothers in law and even members of the public they did not know. The consequences of such perceptions were feeling they had to justify themselves and ADHD as a disorder to family members, and limiting their time in public places where their child’s behaviour and their parenting skills may be viewed critically by other people. Mothers also reported ‘battling’ with their partners whom they perceived to be often ‘unsupportive and dismissive of their concerns about their child’s wellbeing’ (p.332). This theme was present in interviews carried out by Singh (2004), where the 12 fathers of children diagnosed with and receiving drug treatment for ADHD, demonstrated a different understanding of their son’s behaviours from mothers, often perceiving them as not warranting medical intervention; a factor which some of the mothers identified as the reason why one third of the fathers were absent during initial clinical assessments.

In the United States Whalen et al (2006) used electronic diaries to record the moods, behaviours and social contexts in which these occurred, for 27 children diagnosed with ADHD and treated with stimulant pharmacotherapy (18 boys, 9 girls), 25 children with no known problems (15 boys, 10 girls) and their mothers. A signal every 30 minutes prompted participants to choose from a menu of options to record what they were doing, who they were with and how they were feeling. Mothers were also interviewed at the end of the process. Salient differences were found between reported feelings of anger, with mothers of children with ADHD being three times more likely than comparison mothers to be with

their children when feeling angry. When reporting on the quality of interactions with their children with ADHD, mothers were 3.44 times more likely to report disagreeing with their children than mothers in the comparison group. This finding was mirrored in the diaries of children with ADHD, who were over four times more likely to report disagreeing with their mother than the comparison group. Although children in the ADHD group were chosen because they were being treated with pharmacotherapy, mothers still reported lower parenting esteem and perceptions that their child was limiting what the mother and family could do, and therefore overall quality of family life (Whalen et al, 2006).

3.2.2 ADHD and Sibling Relationships

From the research evidence, set out in Section 3.2 and 3.2.1, concerning the impact of ADHD on parental functioning and general quality of family life, it could be assumed that these factors indirectly have a negative influence on sibling relationships, before taking into account the quality of actual interactions between a child with ADHD and their siblings. Mikami and Pfiffner (2008) assert that the systematic study of relationships between siblings in families of children with ADHD is a relatively un-researched area, despite well documented evidence concerning the ‘difficult’ relationships these children have with their parents and peers at school.

Kendall (1999) carried out a three year grounded theory study in the United States with 11 families (parents and children n=43) of boys with ADHD diagnosis recruited through advertisements in community settings, schools, support groups and medical settings. Data were collected using individual and family interviews and weekly diaries. Disruption was reported to be the most significant problem for siblings, whilst the brothers with ADHD

reported 'other people' to be their most significant problem. A theme running through sibling interviews was

'never knowing what was coming next- what problem would have to be dealt with. The question was always when the next problem would occur, not if it would occur' (p. 7)

Siblings reported feeling victimised through overt acts of physical aggression as well as being manipulated and controlled by the self-centredness of their brothers' behaviour. Feelings of sorrow and loss in relation to the 'normal family life' they could not have because of their brother's ADHD were expressed, as well as resentment over parents' expectations that they should 'take care' of, supervise and socially support their sibling with ADHD.

Mikami and Pfiffner (2008) compared sibling relationships of 77 American children diagnosed with ADHD with 14 'non-problem' control children using mother, sibling and self-report. Children were selected for the study on the basis that they were aged five to 11 years and had a sibling aged between four and 18 years. The 'non-problem' children were recruited from the same schools as those with ADHD using flyers and letters. Children were judged to meet the criteria for ADHD on the basis of parent and teacher reports, and data were collected over three clinic visits where diagnostic interviews, psychometric testing and self-report questionnaires were completed. Results showed that there was significantly more conflict in sibling relationships of children with ADHD than those without ADHD, however there was no significant relationship between closeness/warmth and ADHD status.

The research also investigated whether comorbid externalising and internalising problems would impact on sibling relationships; comorbid externalising problems were found significantly to increase conflict, and decrease warmth/closeness in sibling relationships, accounting for much of the difference between the ADHD and 'non-problem' groups on these measures. Internalising comorbid disorders were associated with decreased warmth\ closeness, but had no significant effect on conflict. Mikami and Pfiffner (2008) argue that these findings extend the picture of social impairment amongst children with ADHD, and call for further research on whether parents manage children with and without ADHD in different ways, and how sibling conflict may impact on parenting.

3.3 Parents' Perceptions of Assessment and Diagnosis

There are two separate stages in the diagnostic process of ADHD; identification and assessment (Malacrida, 2004). Research carried out in the USA suggests that teachers are often the first to suggest a child may have ADHD (46%), followed by parents (30%) and then GPs (11%) (Sax & Kautz, 2003). Malacrida (2004) compared British and Canadian mothers' perceptions of educators' roles in the assessment and medicalisation of children with ADHD, and found that in Canada teachers were the main identifiers of children who went on to be diagnosed with ADHD, and mothers often reported them to be directive in suggesting they seek out the label of ADHD and consider treatment with psychostimulant medication. In contrast, British mothers described a strong 'antipathy' from professionals in relation to the medicalisation of children with behavioural problems, with few educators suggesting a diagnosis of ADHD. British mothers reported only having a medical assessment after periods of trying 'traditional interventions by helping professionals' (p.71), when, in the majority of cases, no diagnosis had yet been given.

Much of the research on parental experiences and views of ADHD document frustration with the diagnostic process. Norris and Lloyd (2000) in their review of newspaper articles on ADHD report an emergent theme of parents fighting for months or years to have their child's difficulties recognised by professionals, and either a diagnosis and/or drug treatment provided. In interviews carried out by Harborne et al (2004) parents described professionals as unsympathetic and patronising, and felt as though they had to convince them of their child's difficulties. Parents also expressed confusion and distress in relation to conflicting views of ADHD held by professionals, and only found them helpful when a 'quick and straightforward' diagnosis was given (Harborne et al, 2004).

Handler and DuPaul (2005) used questionnaires to compare the differing practices in the diagnosis of ADHD amongst clinical, counselling and school psychologists, in university, school or outpatient settings in the United States. Findings suggested deviation from recognised 'best practice' (see Section 2.1) with only 60.7% of psychologists indicating that they frequently or very often adhere strictly to the DSM-IV criteria (APA, 2000), 63.9% frequently or very often obtaining information through teacher interview, and although 92.1% of psychologists reported using direct observation frequently or very often, only 37.9% of the time was this during natural situations. Psychologists working in schools were significantly less likely to use DSM-IV criteria (APA, 2000) and interviews with parents and children, than those in outpatient clinics and academic settings. Overall, only 15.3% of the psychologists reported using methods consistent with best practice.

Klasen and Goodman (2000) in their British study carried out with parents and GPs found that GPs reported they were reluctant to 'label' children with ADHD because they viewed it as an ill-defined category that did not lead to useful treatment. The overall time from expressions of concern/identification of a significant developmental difficulty, to provision of an ADHD diagnosis for children reported in the study varied from nine months to five years, with GPs stating that they felt under-trained in the assessment and treatment of hyperactivity, that there was a lack of specialist support services, and often that they did not know to whom they should refer the child for more specialist assessment. The researchers concluded that,

'Referral for specialist help was more often determined by the parents' persistence or inability to cope than by a systematic assessment of the child's symptoms' (p.200).

This apparent inconsistency in the diagnostic process for ADHD is also supported by Travell and Visser (2006) who found that of the 17 young people with ADHD and their parents who were interviewed for their study in a West Midlands metropolitan borough, there was great variation in experiences, with none reporting a 'textbook' diagnosis.

Although research suggests that many parents are frustrated by the diagnostic process, the same studies report that parents often express relief when a diagnosis of ADHD is given (Norris & Lloyd, 2000; Harborne et al, 2004; Singh, 2004). Over half of the 16 parents interviewed by Wright (1997) expressed that they wished their child had been diagnosed with ADHD earlier. The anticipated benefits of this were identified as 'shifting of blame' from parents and earlier access to support and help for both the child and the family. Diagnosis is also reported to improve parent-child relationships by increasing

understanding of behaviour, and allowing parents to consider alternative treatments such as parenting classes, without feeling embarrassed/ashamed (Klasen & Goodman, 2000). Hinton and Wolpert (1998) describe ADHD as the ‘label of forgiveness’; exonerating parents from the blame of poor parenting skills, and opening opportunities such as treatment by medication and extra resources and support in school.

3.3.1 Parental Contribution to Diagnosis

Parents contribute to the assessment and diagnosis of their children with ADHD, not only by monitoring their child’s development and acting on concerns they have by taking them to a doctor or psychologist, but also by providing evidence to inform the diagnostic process. As stated in Section 2.1, recognised ‘best practice’ in diagnosis includes, amongst other assessments and sources of information, a clinical interview with parents and completion of a standardised behaviour checklist by parents (DuPaul & Stoner, 2003). Research in the domain of parental contribution to diagnosis has focussed on differences in parent and youth and parent and teacher reports or ratings of ADHD symptoms and behaviours; the latter are due to the popular practice of using scales to compare children’s behaviour at home and in school in order to determine if symptoms are present across the two contexts required by DSM- IV diagnostic criteria.

Biederman et al, (2007) assert that research has consistently found ‘poor levels of agreement’ between parent and youth reports and suggest this could be due to differing perceptions of clinically significant behaviours, a lack of self-awareness amongst young people with ADHD leading to a false negative diagnosis, or due to the high incidence of mental health problems in parents of children with ADHD, leading to false positive reports

of the disorder. In their own study, in the United States, Biederman et al (2007) compared mothers' reports and combined youth-mother reports of the personal and familial correlates of ADHD in adolescents both with (where evidence of ADHD behaviours were recorded in their medical records) and without the disorder. From the 94 pairs of reports where ADHD was suggested, all were supported by mothers, whilst only half were corroborated by the young person. However when mother only reports were compared with combined mother-youth reports there were no significant differences in the reported clinical correlates, providing support for the hypothesis 'that the diagnosis of ADHD is not subject to maternal informant bias' (p.413).

Research has also shown poor agreement between teacher and parent ratings of ADHD symptoms (Gomez, 2007; Wolraich et al, 2004), with suggested explanations relating either to differential perceptions by parents and teachers and/or situational specificity of ADHD symptoms (Wolraich et al, 2004). Gomez (2007) measured invariance across parent and teacher ratings of 213 children using the Disruptive Behaviour Rating Scale (DBRS, Barkley & Murphy, 1998) in order to determine if their ratings varied from each other. Results confirmed invariance across ratings for all ADHD symptoms, supporting the validity of the requirement to elicit both parent and teacher rating scales. Further evidence of low parent – teacher agreement was also found, with low correlations between parent and teacher ratings on all inattention (IA) and hyperactivity-impulsivity (HI) symptoms and mean IA and HI scale scores based on parent ratings being significantly higher.

Sullivan and Riccio (2007) compared American teacher (n=57) and parental (n=92) ratings of three groups of adolescents: 'no diagnosis' group, ADHD diagnosis group and 'other

clinical' group, on the Behaviour Rating Inventory of Executive Function (BRIEF) (Gioia et al 2000) and Connors Rating Scale Revised- Short Form (Connors, 1997), both of which are commonly used in the diagnosis of ADHD. Allocation of the adolescents to each group was determined by a 'comprehensive psychological evaluation' consisting of a range of cognitive, attention, language, behaviour and emotional measures, carried out by independent chartered psychologists. The study found there was a significant correlation between parent and teacher ratings of adolescents on both scales, indicating a moderate overall level of agreement between them. On both rating scales the ADHD and other clinical group had similar profiles, with significantly higher mean scores on the majority of the measures compared with the no diagnosis group.

Sullivan and Riccio (2007) argue their results indicate that the BRIEF (Gioia et al 2000) and Connors' Forms (Connors. 1997) are efficient at identifying clinical from non-clinical groups, but are not specific enough to distinguish ADHD from other clinical groups, which may be due to problems with executive function being present in a number of different psychiatric disorders. Comorbidity of ADHD with other disorders, and the lack of an objective method of diagnosis, discussed in Sections 1.4 and 2.1, could be argued to undermine the validity of data derived from behavioural checklists, if the behaviours are not exclusive to ADHD and if the adults filling them in, for example parents and/or teachers, have ulterior motives for a diagnosis being given, such as alleviation of blame or access to additional funding and resources. Gomez (2007) asserts that, in contrast to Sullivan and Riccio (2007), his findings of a lack of agreement between parent and teacher ratings imply that further guidance is needed in relation to the 'two settings' across which the DSM-IV criteria require some 'clinically significant impairment' in functioning.

3.4 Parental Experiences and Perceptions of Treatment Options for ADHD and their Effectiveness

The majority of the research literature documents a positive response from parents to drug treatment for ADHD (Wright, 1997; Singh, 2004; Travell & Visser, 2006); however many studies also record the dilemmas and difficult decision making processes parents go through concerning how best to support their child (Bussing et al, 2003; Hansen & Hansen, 2006; Taylor, O'Donoghue & Houghton, 2006). When discussing the treatment decisions made by parents it is necessary to consider the evidence in the context of the availability of different options, those recommended by medical practitioners working with the family, and influences on these factors, such as cost of treatment, differences in local availability and policy (see Section 2.2), and the power relationships between professionals and parents (see Section 4).

Wright (1997) in interviews with 16 parents, whose children were currently receiving drug treatment for ADHD, documents an 'overwhelmingly positive' response to methylphenidate, with parents reporting children as being calmer, more compliant, less aggressive, more affectionate and having improved concentration. Parents expressed that their child's behaviour and concentration in school had improved, although it was too early to judge if this had benefited their academic work. Travell and Visser (2006) found parents perceived the advantages of medication to be greater rationality and obedience at home and improved schoolwork. Singh (2004) found mothers felt the benefits of methylphenidate extended beyond changes in their sons' behaviour, to improving relationships with their husband, son and school staff, allowing the family to access activities in the community,

increasing the mothers' feelings of happiness and reducing anxiety. Fathers also reported reductions in anxiety displayed by their wives and an improvement in family life, even if they did not believe anything to be medically wrong with their son. Singh (2004) summarises the impact of psychostimulant treatment as,

'Freed from the burden of responsibility for causing their sons' behaviors, mothers felt they were finally empowered to "do something," and Ritalin was an important aspect of this doing.' (p.1201)

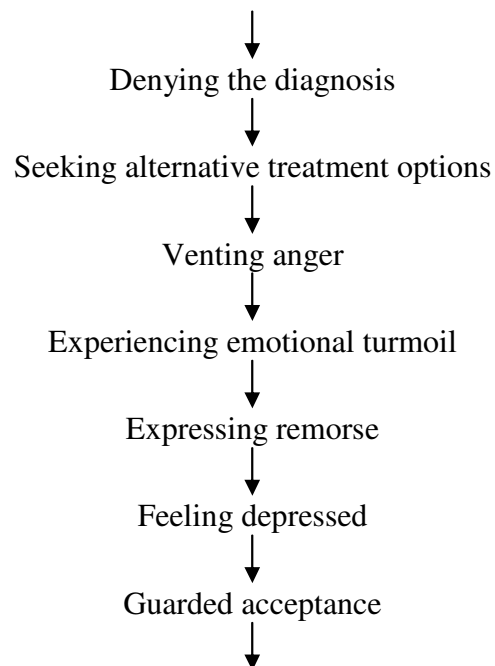
Hansen and Hansen (2006) carried out a small scale interview study, from a constructivist view point, with 10 Canadian parents in order to gain insight into their daily experiences of their child's stimulant treatment for ADHD. They found parents described a 'flux of dilemmas' including balancing the improvements caused by medication with their side effects, the consequences of their child coming off medication, and concerns about their child's future on medication. Hansen and Hansen (2006) noted a relationship between parents' treatment goals and the functional benefits they reported; for example parents whose main goal related to improving their child's behaviour at school, focussed on benefits relating to this. Parents specified improvements at home as including reduction in stress and an increase in their ability to cope, better one-to-one interactions with their child, and more peaceful relationships between siblings. The majority of parents reported their child experiencing side effects of reduced appetite and/ or difficulties sleeping at some point; however the intensity of effects varied from a 'zombie effect' to being barely noticeable. Other parents expressed anxiety and stress when balancing positive effects of medication on school work, with concerns about the (high) dosage required to produce them.

Taylor et al (2006) used a grounded theory approach to carry out semi-structured interviews with five fathers and 28 mothers of children diagnosed with ADHD in Perth, Australia. They found the prominent theory of ‘doing right by my child’, which consisted of three stages: grieving, cynicism and proactive parenting, presented in Figure 2, with their sub-stages. Interestingly within this study, ‘seeking alternative treatment options’ was viewed by the parents as a stage necessary to pass through before accepting ‘medication is the only viable treatment option for their child’ (p. 118). Parents reported trying behaviour modification, restricted diets, vitamin and mineral supplements, and eye tracking exercises, as well as seeking advice from psychologists and occupational therapists. Ultimately they expressed frustration at the expense of exploring alternative treatment options and scepticism over their long-term effectiveness.

As parents reached the seventh sub-stage of grieving: ‘guarded acceptance’ Taylor et al (2006) found this was where parents ultimately made the decision about whether or not to medicate their child. Here parents asserted that failure to find a sustainable alternative to medication resulted in their starting drug treatment ‘by default’, as the only visible option left for them to try. Regarding debate over the drug treatment of children with ADHD parents expressed anger at judgements made about their parenting skills and choices, distrust concerning the government’s choice to place methylphenidate on the Pharmaceutical Benefits Scheme and anger at the dichotomous and sensationalised stories about ADHD in the media.

Figure 2: The stages and Sub-stages in the Parental Theory of ‘doing right by my child’ (adapted from Taylor et al, 2006)

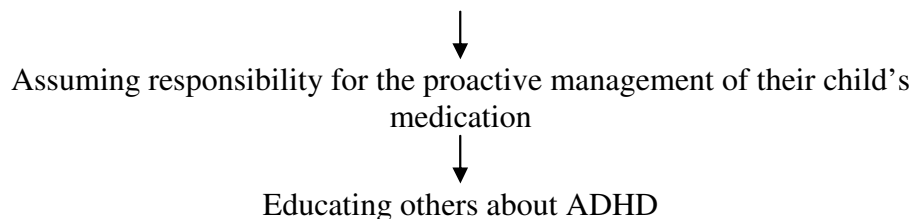
Stage 1: parents’ grieving over the loss of the child’s ‘normal’ status



Stage 2: Parental cynicism of society’s dichotomous attitude towards ADHD and the use of medication as the preferred treatment option



Stage 3: adopting proactive parenting practices- ‘doing the right thing by my child’



The final suggested stage in the adaptation process involves parents taking responsibility for the administration of their child's medication and educating others about ADHD. Parents reported few paediatricians provided guidance on how to administer ADHD medication to lessen side effects, and in response to this many parents took on the role of titrating their child's medication, often using 'trial and error' in order to achieve the most beneficial results.

Other research has highlighted a lack of monitoring of medication for ADHD when it is initially prescribed, as well as few alternative treatment options being trialled before resorting to medication, steps both recommended as good practice by NICE guidelines (NICE, 2008b). Travell and Visser (2006) assert that in their West Midlands study there was little evidence of 'comprehensive multi-modal treatment programmes' being put into place. Some parents and young people reported trying interventions such as restricted diets and behaviour programmes prior to diagnosis; however the majority of young people were on medication as their sole treatment, some with additional, but not consistent, use of a behaviour chart at home. Similarly Wright (1997) asserts that amongst her relatively small sample of 17 parents, there were no standardised practices for monitoring medication, with responsibility shared out amongst psychiatrists, parents and GPs, with schools only contributing in two cases. In none of the cases was medication combined with an alternative intervention such as parenting classes or cognitive behavioural therapy.

The above studies carried out with parents of children with ADHD, although positive in their findings about drug treatment and its perceived effects on children's behaviour, share sometimes subtle, and in other cases, dominant themes of frustration and confusion in relation to the mixed messages parents receive concerning the treatment of their child's ADHD. Drug

treatment appeared to be the only effective or available option as far as many parents were concerned, the only contradiction to this arising from Bussing et al's (2003) finding that parents most frequently requested psychosocial interventions, followed by drug treatment. Overall parents seemed to have a good understanding of the effects of medication, both positive and negative, on their child's behaviour and how to manage this through controlling the dose they received. However Baldwin (2000) found that amongst the 80 families in his UK study none reported having been told about the possible addictive properties of methylphenidate (still claimed to be a risk by anti-drug treatment researchers despite evidence of low tolerance and addictive properties- see Table 3), and more alarmingly, none had been offered alternative treatments.

4. Discussion: Consideration of EP Practice when Working with Parents, Schools and Other Professionals, Drawing on Two Case Studies, with Reference to Current Thinking about ADHD and Research on Parental Understanding of ADHD.

Child A and Child B are two examples from a number of children and young people whom I have encountered during two years work as a Trainee Educational Psychologist (TEP) within a West Midlands Local Authority. Both children attend inner city primary schools in an area of relatively high social disadvantage; both are of White-British ethnicity, and come from families where their parents are unemployed. I have chosen these two cases because they highlight contrasting parental views on ADHD, differing views between parents and the school regarding whether their child has ADHD, and the disparate views held by professionals working with the pupils. Interestingly, as epidemiological studies would suggest

(CDC, 2002) both of these case studies are males, and whilst working with them I only had contact with their mothers, even though a father and a partner were present in both homes: something which Singh (2004) would argue adds to an attitude of ‘mother-blame’ within society.

In both cases the children and families had a number of different professionals working with them, of which I was one. Child A’s family was supported by the local Children’s Centre, targeted family support had been provided through social services and monitoring from this service remained ongoing. A Common Assessment Framework (CAF) had been used with the family, and supported by a number of the professionals, to set objectives relating to improving housing and providing extra curricular activities for the children in the family. The mother also reported attending, although not completing, a number of parenting courses which had been recommended by the Children’s Centre. I worked with both the school and A’s mother to identify positive behaviour management strategies that could be use in the classroom and at home.

Child B and his mother were also supported by social services, who had been involved with the mother before Child B was born. A Primary Mental Health Worker (PMHW) visited the home on several occasions to discuss behaviour management with the mother, and to encourage engagement with Child and Adolescent Mental Health Services (CAMHS). In Child B’s case I had supported the school over a period of two years to put positive behaviour management strategies in place, on an individual, whole class and whole school basis. I also wrote the psychological advice for B’s statutory assessment.

Case A

Child A is five years old and is in the Reception class at his local primary school. The school referred him to the educational psychology service following his first 6 weeks of attendance due to his disruptive behaviour, lack of compliance with adult directions and because of concerns his mother had shared in relation to his behaviour at home, and in the nursery he attended previously.

Although behavioural interventions were supported by the school EP, the child's teacher was reluctant to engage with them, indicating that she felt the child was 'un-teachable'. Initial EP classroom observations highlighted a lack of positive behaviour management and low teacher expectations in relation to work outcomes.

Child A is from a large family, where a number of his older siblings have received additional educational support and have identified learning difficulties and/or ADHD. The mother was persistent in her assertions that the child needed to be on medication, and the school reinforced this view by frequently giving negative feedback to the mother, and suggesting her child's needs would be best met in a special school.

When the child reached the age of five he began drug treatment, despite a written letter from the TEP to the doctor detailing her observations of how he was being managed in school, and his relatively calm behaviour and ability to concentrate when working on a one to one basis with her. The school, and mother, reported instant improvement in his behaviour; however it was noted that his medication appeared to "wear off" in the afternoons. Moreover deterioration in his behaviour was seen following a period of disruption in his family life.

Currently Child A has three hours of one to one support in class and over lunch time from a Teaching Assistant. This has proved sufficient for his mother to suspend requesting a statutory assessment in order for him to access special school.

Case B

Child B is nine years old and in a Year 4 class in his local primary school. He has attended his current school since Year 2, but was on a reduced timetable at his previous primary school, only attending 2 hours per day.

Teacher reports and TEP observations of child B in class confirm that he consistently shows the symptoms of ADHD described in Section 1.2. He is impulsive, frequently shouting out, getting out of his seat or leaving the classroom. When taught in smaller groups and in response to certain teachers his behaviour appears to improve. According to his teacher he finds it difficult to form relationships with other children and is socially isolated. The school's TEP has been involved in writing behavioural plans and monitoring child B's behaviour over a period of two years. However, a combination of his current class teacher being absent due to stress, and additional support to prevent exclusion now being withdrawn, resulted in the school requesting a statutory assessment be carried out.

Child B is an only child whose mother has a partner and is supported by a social worker and her sister. Mother reportedly has limited contact with the school, avoiding meetings and feedback from the teacher at the end of the day. Child B has had an initial assessment by CAMHS, resulting in the prescription of medication, in response to which the school reported an improvement in his behaviour.

Child B's mother has not taken him to check up appointments with CAMHS, resulting in the need for him to be re-referred and move through the waiting list again. His mother took him off medication after several months due to an allergic reaction he experienced, which she related to the Ritalin; however his GP felt it was a reaction to food. During a recent meeting with Child B's mother she stated that she was able to manage his behaviour at home and that she did not want him 'drugged up to the eyeballs' on medication. Within this meeting the school expressed the opinion that they could no longer meet his needs and that they felt a statutory assessment was required. Child B's mother agreed to the statutory assessment, but not with the school's view that a special school placement was required.

4.1 EP Role in Raising Awareness and Supporting Parents of Children with ADHD

The literature on ADHD details a dichotomous conceptualisation of it as a disorder, or as a social phenomenon characterised by reactions to adverse life circumstances or poor parenting/behaviour management. These incomplete views are often religiously adhered to and promoted by different groups of professionals, and parents. Although parents tend more frequently to adopt biomedical explanations of ADHD (Klasen & Goodman, 2000; Norris & Lloyd, 2000; Harborne et al, 2004; Travell & Visser, 2006), they also express confusion and distress at contrasting opinions represented in the media and amongst some professionals (Harborne et al, 2004). I would argue that whether parents prefer biomedical accounts because they offer absolution from ‘guilt and responsibility’ (Hinton and Wolpert, 1998; Singh, 2004) or because they interpret the effectiveness of psychotherapeutic drugs as evidence for this (Rapport et al, 1980) is unimportant. Advocating a bio-psychosocial understanding of ADHD, whilst the causes and aetiology are still being researched (Cooper, 2001), will act to improve outcomes for children with ADHD by increasing parents’ understanding of their child’s behaviour and the likelihood that they will support multi-modal intervention for their child.

Presenting a bio-psychosocial explanation of ADHD (Frith, 1992; Cooper 2001) may act to absolve some parents from the blame they feel from others in relation to their child’s behaviour, whilst also providing them with an understanding of that behaviour and how it is influenced by the environment, at home and school (BPS, 2000). Such an approach may also reduce the anxiety and confusion parents report when professionals, and the media, present them with dichotomous views of ADHD (Norris and Lloyd, 2000; Harborne et al, 2004). By recognising the influence of biological and behavioural factors on ADHD the bio-psychosocial approach could lead to multimodal treatment and approaches of minimal

invasiveness recommended by the BPS (2000), whilst improving outcomes for the 25-30% of young people who do not respond to medication, (DuPaul & Stoner, 2003) or for whom drugs produce unmanageable side effects (Baldwin, 2000).

In Case A, a united presentation by professionals of the bio-psychosocial approach to the child's mother may have influenced her to attend the recommended parenting courses, and encouraged her to allow the establishment of 'positive behaviour management' strategies suggested to the school by the TEP, before opting for medication. In cases similar to Child A, where professionals have suggested that the family may benefit from parenting support, or where social services are involved, empowering parents to recognise that their management of behaviour may prove equally as important as the effects of drugs and is likely to improve outcomes for other siblings living within the home.

In Case B, where the child is close to permanent exclusion, and the alternative option is a special school for children with behaviour problems, often with poor educational outcomes, the bio-psychosocial model may also be helpful in challenging his mother's thinking. A balanced presentation of the treatment options available to the mother, and the recognition of her currently effective strategies for managing her son's behaviour at home, may not eradicate the value of ADHD as a diagnosis, could have lead to greater positive engagement with the school and other services. It appears in this case that the mother felt under considerable pressure from the school and medical professionals to medicate her son, resulting in her opting out of appointments and meetings. Additionally the mother may benefit from understanding the different types of psychotherapeutic treatment available to her son, how they work and their advantages and disadvantages, in order for her to consider trialling them

for a limited period to determine if they improve her son's access to education in mainstream school.

Finally, in response to research which highlights fathers' lack of participation in the assessment and diagnosis of ADHD (Singh, 2004), and the impact this has on family functioning (Klasen & Goodman, 2000; Whalen et al, 2006) EPs are in a position to encourage the involvement of both parents. In practice this could occur through emphasising the importance of father and/or extended family support to schools; advocating their invitation to meetings, and arranging meetings/ reviews out of normal working hours or within the home environment to increase access for fathers. The involvement and contribution of fathers or wider family may allow the mother to feel more supported less defensive about perceived blame and therefore be more open to a bio-psychosocial understanding of ADHD and multimodal intervention.

4.2 EP Role in Working with Teachers and Schools Where Pupils have/are Suspected of Having ADHD

Contrary to Malacrida's (2004) findings of 'antipathy' from British professionals in relation to the diagnosis and medical treatment of ADHD, my experience of working in schools, four years after the publication of the fore-mentioned research, is one where teachers and others working for Children's Services are quick to suggest ADHD in cases where challenging behaviour is displayed. Because of the power relationships which exist between parents, teachers, and other professionals, this proposed diagnosis by teachers can be disempowering to those parents who may take a different view, leading either to disengagement from services, as in Case B, or a polarised understanding of ADHD and its treatment, highlighted by Case A.

It could be argued that increased teacher identification of ADHD amongst their pupils, and their encouragement of parents to seek a diagnosis, is fuelled by media coverage of this issue (Norris & Lloyd, 2000). In response, EPs, and other professionals, have a role in presenting balanced and factual accounts of ADHD, its aetiology, epidemiology, and the DSM-IV (APA, 2000) criteria against which it is diagnosed (See Section 4.3). The focus of this report has been on parents', rather than teachers' understanding of ADHD. However, similar arguments about 'blame' and competency in managing a child's challenging behaviour apply. Increasing teachers' understanding of the complexities surrounding ADHD, its symptoms, diagnosis and treatment, may encourage them to work collaboratively with parents, and empower them to have some positive influence on pupils' behaviour (possibly in combination with drug treatment) through management of the classroom environment.

In Case A, the Reception teacher had developed a negative view of Child A based on her perception that it would be impossible to meet his needs within a mainstream school; a perception which was compounded by his mother's medicalisation of his challenging behaviour. The teacher reported that she felt she was unable to influence his behaviour and classroom observations suggested she had effectively stopped using any form of positive behaviour management. In this example I feel the whole school would have benefited from general training on ADHD and the importance of multimodal intervention, of which classroom management would be a part. Similar challenges were present in Case B; however the teacher was 'signed off' sick from work by her doctor, limiting the support the Educational Psychology Service, and other professionals could offer her. Again, raising awareness of the advantages and disadvantages of drug treatment and the alternatives to it,

may have reduced the pressure the school put on the mother to give her child medication, and prevented the breakdown in collaborative working.

4.3 EP Role in the Diagnosis and Treatment of Children with ADHD

EPs are not mentioned in the NICE guidelines (2008a) among specialists in ADHD who are qualified for diagnosis. This is supported by the British Psychological Society (2000) which emphasises the importance of diagnosis being carried out by a paediatrician or child psychiatrist; however the society report also advocates a multi-agency contribution to assessment, especially where other professionals are involved with the child and have had the opportunity to work with them and observe their behaviour in a number of settings.

Within the West Midlands LA, where the case studies are based, local guidelines or policy on the diagnosis of ADHD appear to be elusive, and as a result a variety of practice takes place. Case A is the sole experience I have had of a medical professional requesting my views on Child A's strengths and difficulties, although ultimately these views were contradicted by teacher and parent responses. In the majority of cases it appears that parents' and teachers' views are sought through a behaviour checklist, such as the Conners' Rating Scale (Conners, 1997) and that the child is assessed in clinic; however rarely is the child observed at home or in school, something which is recognised as 'good practice' by many professionals (DuPaul & Stoner, 2003).

The practice of medical professionals observing children's behaviour in clinic only, enhances the importance of parent and teacher contributions, particularly through the completion of behaviour checklists. In cases A and B I have felt that the accurate completion of such

checklists may have been compromised by teachers' and parents' agendas. In Case A it could be argued that the teacher had multiple motives for filling in the checklist to indicate extreme behaviour; these included exonerating her teaching skills from any blame, reinforcing the messages she was giving to A's mother about the school not being able to meet his needs, whilst also opening avenues to request increased funding to support the child. The validity of the checklist filled in for Child B could also be queried, because of the 'stress' the class teacher reported to be experiencing and perceptions expressed by the Special Educational Needs Co-ordinator that Child B's needs would be best met in a special school. It is also important to consider the reliability of the parent's contributions to such checklists when there may be underlying motives relating to Disability Allowance which can be claimed following such diagnoses. This highlights the importance of professionals, including EPs, who may have had the opportunity to observe the child in different environments contributing to multi-agency diagnosis or submitting their views and evidence to the medical professional carrying out the assessment.

Finally EPs are in a position to encourage parents and teachers to take a proactive role in monitoring the effects, both positive and negative, of any psychotherapeutic treatment of ADHD. Research suggests that often monitoring and management of medication is carried out by parents in isolation (Wright, 1997; Travell & Visser, 2006). EPs can support schools and parents to choose appropriate behaviour and subjective measures to judge the impact of medication, and to provide reliable feedback to medical professionals.

5. Conclusions

ADHD, at least for the present, is likely to remain a contentious disorder, with contrasting viewpoints advocated by professionals, parents and the media. Epidemiological research on this disorder is subject to criticism because studies use varying criteria for inclusion and the lack of national databases to record diagnoses has resulted in reliance on correlations with psychotherapeutic drug production. Although there are two recognised diagnostic criteria for ADHD, research suggests that these are not always adhered to by medical professionals, and that the ICD-10 criteria (WHO, 1990) may be less inclusive than the DSM-IV (APA, 2000), which has implications for prevalence studies. Finally there remains uncertainty about the causes of ADHD and, resulting from this, the most effective way to treat it. Although the effectiveness of psychotherapeutic drug treatment is recognised within the research, it is not successful for all children all of the time, providing support for multi-modal intervention as a viable treatment option.

Research on parents' perceptions of ADHD suggests that often they feel confused and frustrated by the differing conceptualisations of their child's difficulties and the options for treating them. One clear theme amongst the studies is that often parents', particularly mothers', felt blamed by their partners/spouses, wider family and teachers for their child's difficulties and that this, in addition to the managing their child's behaviour at home, puts stress on their family life and their own well-being.

Based on the research findings summarised above, and the two case studies discussed within Section 4, I would argue that it is important for EPs to put aside any polarised views they may personally hold concerning the causes of ADHD and advocate a bio-psychosocial stance,

incorporating both behavioural and medical influences. It is clear from the research that dichotomous views can act to confuse and alienate both parents and teachers who are involved in meeting the needs of children with ADHD, resulting in the breakdown of collaborative assessment and intervention for the child, as evident in the cases studies.

If professionals, such as EPs, take a role in educating teachers and parents about ADHD, rather than this occurring through sensationalist media stories, they can promote a balanced and accurate understanding of ADHD, its aetiology, epidemiology, diagnosis and treatment options. Increasing this understanding amongst parents and teachers should lead to more effective and accurate multi-agency assessment and multi-modal intervention for the child, recognised as best practice in the diagnosis and treatment of ADHD.

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Appendix 1

DSM-IV-TR Diagnostic Criteria for ADHD (APA, 2000)

A. Either (1) or (2):

(1) Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention:

- (a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- (b) often has difficulty sustaining attention in tasks or play activities
- (c) often does not seem to listen when spoken to directly
- (d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions)
- (e) often has difficulty organizing tasks and activities
- (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- (h) is often easily distracted by extraneous stimuli
- (i) is often forgetful in daily activities

(2) six (or more) of the following symptoms of hyperactivity-impulsivity have been persistent for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity:

- (a) often fidgets with hands or feet or squirms in seat
- (b) often leaves seat in classroom or other situations in which remaining seated is expected

- (c) often runs about or climbs excessively in situations it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- (d) often has difficulty playing or engaging in leisure activities quietly
- (e) is often “on the go” or often acts as if “driven by a motor”
- (f) often talks excessively

Impulsivity:

- (g) often blurts out answers before questions have been completed
- (h) often has difficulty awaiting turn
- (i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairments were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinical significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Code Based On Type:

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months

314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months

CHAPTER SIX

WHAT DIFFERENCE WILL A STATEMENT MAKE? THE VIEWS OF STAKEHOLDERS IN SIX CASES CURRENTLY UNDERGOING STATUTORY ASSESSMENT, WITH REFERENCE TO RESEARCH ON PARENTS' AND CHILDREN'S VIEWS OF THE STATEMENTING PROCESS

WHAT DIFFERENCE WILL A STATEMENT MAKE? THE VIEWS OF
STAKEHOLDERS IN SIX CASES CURRENTLY UNDERGOING
STATUTORY ASSESSMENT, WITH REFERENCE TO RESEARCH ON
PARENTS' AND CHILDREN'S VIEWS OF THE STATEMENTING
PROCESS

Abstract

Producing psychological advice in order to contribute to statutory assessment can take up a large amount of educational psychologists' time. Although the DCSF (2009) reports a decrease of 0.2% in the number of children with statements between 2006-2009, there has been an increase in the number of statutory assessment taking place from 24,800 in the calendar year of 2007 to over 26, 500 in 2008. This report provides a brief summary of the concept of special educational needs (SEN) and how over the last 20 years related policy and procedures have developed. Research on the criticisms of the statutory assessment process in relation to its inclusivity, cost and equitability are summarised. In an attempt to add to the scarce research on stakeholders' view of statements, the views of parents, children and teachers in six cases currently undergoing statutory assessment are presented. These views are then discussed in relation to the disadvantages of the system and existing published research on stakeholders' views. It is concluded that many of the hopes held by parents in the case studies contrast with the research findings, and that further research on stakeholders' views is required to inform any changes to the current statutory assessment process.

WHAT DIFFERENCE WILL A STATEMENT MAKE? THE VIEWS OF STAKEHOLDERS IN SIX CASES CURRENTLY UNDERGOING STATUTORY ASSESSMENT, WITH REFERENCE TO RESEARCH ON PARENTS' AND CHILDREN'S VIEWS OF, AND CRITICISMS OF, THE STATEMENTING PROCESS

1. Introduction

Statements of Special Educational Needs (SEN) have been in use in England for over 25 years, since the implementation of the 1981 Education Act (Florain, 2002), which arguably marked a pivotal change in Britain's understanding of assessment and provision for children considered to have 'additional educational needs'. Yearly figures published by the DCSF (2009) indicate that in January 2009 2.7% of all pupils in schools across England had statements; of whom 55.6% are educated in mainstream school, 37.5% in maintained specials schools and 3.9% in independent schools. Currently there are 1.4 million (17.8%) pupils in schools who have SEN without a statement: an increase of 0.6% from 2008.

This report introduces the concept of SEN within England, and outlines the legislation that has lead to today's practice of Statutory Assessment and the conceptualisation of SEN through the Code of Practice (DfES, 2001). Criticisms of the current system and the use of statements are presented, with a particular focus on the role of categories and labels, the

inclusiveness of statements, their cost and effectiveness in the equitable management of resources.

Part of my role as a Trainee Educational Psychologist employed by a West Midlands Local Authority is to carry out any statutory assessment work in the schools in which I work. This report provides an overview of practice and policy in relation to the assessment of special educational needs within the Local Authority (LA) in which I work. Within this context the cases of six pupils currently undergoing statutory assessment are briefly outlined. In order to contribute to the psychological advice written for each of these children it is common practice to elicit and represent the views of parents/ carers, the school and the child concerning why the statutory assessment has been requested and what the stakeholders hope its outcomes will be. The views of these stakeholders are explored within this report with reference to the existing (albeit limited) research on parents' and children's views of the statutory assessment process and criticisms of the current statementing system.

1.1 The Concept of SEN

Fredrickson and Cline (2009) argue 'it is the perception of difference' that is fundamental in the grouping/categorisation of children with additional needs and the choice of criteria and 'names' by which these groups are defined. Currently two main terms are used 'SEN' and 'additional educational needs' (AEN). Children with SEN are defined in the Education Acts 1981 and 1996 (section 312) as having a learning difficulty which requires special educational provision be made for them. For children aged five or over, a learning difficulty is conceptualised as 'significantly greater difficulty' with learning in comparison to the majority

of peers, or a disability which prevents access to or use of educational facilities provided for peers within schools in the same Local Authority (LA).

The DfES (2006) describes children with AEN as those at risk of poor outcomes in the five areas identified in Every Child Matters (ECM) (DfES, 2003): being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being (see Table 1). However the DfES also recognise that amongst the 20-30% of children who will have additional needs at some time in their education there is a proportion with ‘complex or significant’ needs, who may meet the criteria for statutory assessment.

Table 1- Guidance on AEN and Significant/Complex needs set out in the Common Assessment Framework (DfES, 2006a)

Additional Educational Needs	Significant or Complex Needs
<ul style="list-style-type: none"> • Disruptive or anti-social behaviour • Overt parental conflict or lack of parental support/boundaries • Involvement in or risk of offending • Poor attendance or exclusion from school • Experiencing bullying • Special educational needs • Disabilities • Disengagement from education, training or employment post-16 • Poor nutrition • Ill-health • Substance misuse 	<ul style="list-style-type: none"> • Children who are the subject of a child protection plan • Looked after children • Care leavers • Children for whom adoption is the plan • Children with severe and complex SEN • Children with complex disabilities or complex health needs • Children diagnosed with significant mental health problems • Young offenders involved with Youth Justice services (community and custodial)

<ul style="list-style-type: none"> • Anxiety or depressions • Housing issues • Pregnancy or parenthood 	
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Independent of the name given to SEN, are two different ways in which it can be conceptualised, with a focus on individual differences or environmental demands. Conceptualising SEN as a product of individual differences reflects the approach adopted by the government prior to the Education Act, 1981, where children were allocated to categories of handicap (see Section 1.2, Figure 1) and external factors, such as methods of teaching, were little considered (Fredrickson & Cline, 2009). Lindsey (2003) asserts that within education there has been a general shift from focusing on ‘within child’ factors to understanding SEN through a social model of disability which recognises the influence of community, school and home environments and the child’s own strengths and difficulties. Related to the social model is the conceptualisation of a child’s SEN through the environmental demands of the provision made to address their needs. Such an approach suggests that a child’s current attainment reflects the quality of teaching and learning experiences, rather than their own abilities (Soly, 1996).

The interactive model (Wedell & Lindsay, 1980) arguably provides a compromise between individual differences and environmental understandings of children’s needs by viewing them as the product of interactions between the child’s inherent characteristics, supports and barriers within the environment, and time (because patterns of interaction may change). The influence of social and educational context is identified in the SEN Code of Practice (DfES, 2001) which states that the school’s learning environment and adult/child relationships can exacerbate some children’s difficulties. Norwich (2008), however, asserts that the language

of SEN reflects the use of a deficit model, irrespective of how it is conceptualised: by identifying and responding to individual differences a child is put at risk of experiencing rejection, stigma and limited opportunity; however, choosing not to respond to differences may produce comparable negative results.

1.2 Historical Context of SEN and Statements

Development of the special school sector occurred under the 1870 Education Act which entitled all children to an education. Prior to this there were few special schools and these were often run by charitable organisations. The Education Act 1944 identified 11 categories of handicap or disability (see Figure 1) amongst children for whom Local Education Authorities were required to make special educational treatment (DES, 1978).

<u>Figure 1- 11 Categories of Disability Established in the Education Act 1944</u>	
<ul style="list-style-type: none">• Blind• Partially sighted• Deaf• Partially deaf• Physically handicapped• Delicate	<ul style="list-style-type: none">• Educationally subnormal (moderate or severe)• Epileptic• Maladjusted• Speech defects• Autistic
(Fredrickson & Cline, 2009)	

In 1974 the English government appointed a committee to review the educational provision in England, Scotland and Wales for ‘children and young people handicapped by disabilities of body or mind’ (DES, 1978). The committee published their findings in the Warnock Report (DES, 1978), which, amongst other things, proposed the abolition of statutory categorisation of handicapped pupils, arguing that children often had a range of needs which prevented them fitting

into one category and children within one category may require different educational provision. The report proposed a new conceptualisation of ‘special educational needs’,

‘not in terms of a particular disability which a child may be judged to have, but in relation to everything about him, his abilities as well as his disabilities- indeed all the factors which have a bearing on his educational progress’ (p. 37),

a definition still used today, which is restated in the Code of Practice, (DfEE, 2001).

The different forms of special provision identified by the Report are outlined in Figure 2, with the recognition that children may have a combination of needs. Although the report recognised the inflexibility and flaws in the existing system of allocating children to a statutory category of handicap, it also appreciated that descriptive terms were necessary for discourse about such children to take place. The Report recommended that children with SEN, currently labelled ‘educationally sub-normal’ be described as ‘children with learning difficulties’, using further descriptors of ‘mild’, ‘moderate’, ‘severe’ and ‘specific learning difficulties’, which were also used to describe types of specialist provision.

Figure 2- The Warnock Report’s Broad Descriptors of Special Educational Provision

- (i) the provision of special means of access to the curriculum through special equipment, facilities or resources, modification of the physical environment or specialist teaching technique
 - (ii) the provision of a special or modified curriculum
 - (iii) particular attention to the social structure and emotional climate in which education takes place
- (DES, 1978)

The 1981 Education Act was the means through which the Warnock Report (DES, 1978) was operationalised. It introduced the legal concept of SEN, placed the responsibility for assessment of and provision for SEN within the remit of Local Education Authorities and strengthened the rights of children and their parents within this process (Farrell, 2001).

1.3 The Current Context of SEN

Local Authorities currently adhere to the Special Educational Needs Code of Practice (DfES, 2001) which re-emphasises fundamental principles set out in the 1981 Education Act, such as: children with SEN should have their needs met and this will be normally within a mainstream setting. The Code of Practice (DfES, 2001) provides guidance on the identification, assessment and provision for children with SEN, emphasising the importance of a graduated response to the continuum of SEN (Fredrickson & Cline, 2009). Closely related to the SEN Code of Practice (DfES, 2001) is the SEN Disability Act 2001 (SENDA) which extended the Disability Discrimination Act (DDA) 1995, giving rights to children who are disabled and who need special educational provision to be made in order for them to access the education which is available locally (DfES, 2006b). Under the Disability Discrimination Act 2005 the definition of a 'disabled person' includes difficulties resulting from dyslexia, autistic spectrum disorders, diabetes and severe asthma.

The SENCO (Special Educational Needs Co-ordinator) is named as the person responsible for 'coordinating SEN provision within the school', and is accountable to the Head Teacher and the governor responsible for overseeing SEN. A Statutory Assessment can be requested by a pupil's school, parents or another agency within Children's Services, where different educational provision/ interventions have been tried over a reasonable period of time and

concerns remain about a child's progress. If a statement is issued parents have a right to appeal to the SEN Tribunal if they disagree with type or extent of provision detailed in it (DfES, 2001).

The current statutory framework has been established for over 25 years since the Education Act, 1981 was passed, with further refining and extending of provision through subsequent acts (Farrell, 2001). However it is subject to a number of criticisms, some which have been voiced over many years. For example Florain (2002) in her response the Audit Commissions (2002) review of provision for children with SEN asserts,

‘Have we not heard all this before? Was there not another Audit Commission's report ten years ago that made similar points about the problems of meeting special educational needs?’ (p. 164)

Within Section 2 the main criticisms of the current statutory framework will be considered with reference to three recent reports/inquiries into the processes and provision for SEN within England and Wales by the Audit Commission (2002), Ofsted (2004) and the House of Commons Education and Skills Committee (2006).

2. Criticisms of Statutory Assessment

2.1 How Inclusive are Statements?

2.1.1 What is inclusion?

The level of priority invested in inclusion by the government is seen as a relatively recent phenomenon, introduced in the Excellence for all Children: Meeting Special Educational Needs (DfEE, 1997) document. However the language and ideas of inclusion were evident in

earlier Government documents such as the Warnock Report (DES, 1978) and the 1981 Education Act (see Section 1.2). The Salamanca Statement (UNESCO, 1994) is viewed as the main catalyst for inclusion in the British education system (Hodkinson, 2005) and was the product of the World Conference on Special Needs Education. In its statement of belief it called on governments to adopt the principle of inclusive education, by enrolling 'all children in regular schools unless there are compelling reasons for doing otherwise' (UNESCO, 1994, p.44).

Hornby (2002) highlights the difficulty of defining inclusion as a concept, suggesting that the literature in this area documents the tensions that exist in relation to the definition and meaning of inclusion. The DfEE (1997) describes inclusion as a process, not a fixed state,

‘By inclusion, we mean not only that pupils with SEN should wherever possible receive their education in a mainstream school, but also that they should join fully with their peers in the curriculum and life of the school.’ (p.44)

Hodkinson (2005) criticises the conceptualisation of inclusion in government documentation in the late 1990s where inclusive education was viewed as teaching disabled and non-disabled children within schools in the same neighbourhood. Hodkinson (2005) argues that the DfEE (1997) definition relates to ‘locational inclusion’: that a child being educated in mainstream provision is more important than their experience of education. In later guidance, such as *Removing Barriers to Achievement* (DfES, 2004) the government adjusted their definition of inclusion to recognise that it was more than the type of school a child attended, but also referred to their experience of and ability to participate in education,

‘inclusion is about much more than the type of school that children attend: it is about the quality of their experience; how they are helped to learn, achieve and participate fully in the life of the school.’ (p.25)

Norwich (1999) distinguishes between four possible models of inclusion set out in Table 2; it could be argued that the current system within England accommodates all of the models, with the exception of full non-separatist inclusion.

Table 2: Models of Inclusion and Integration

Models of Inclusion (Norwich, 1999)	
Full non-separatist inclusion	The full diversity of individual need is accommodated without any additional provision, but as part of normal practice.
Participation in the same place	Additional systems of support, or different provision, are put in place to support inclusion in mainstream school
Focus on individual need	Inclusion only supported if this meets the needs of the child and so allows for special school placement if this will benefit the child in the long term
Elective inclusion	Parents and child can choose whether the child attends mainstream or special school
Levels of Integration identified (DES, 1978)	
Level 1	Describes the location of SEN provision, for example the location of a SEN unit or class within a mainstream school
Level 2	Describes the degree of social interaction experienced by a child with SEN, for example, children from an SEN unit eat their dinners, or have playtimes, with mainstream pupils
Level 3	Described as ‘functional integration’, where pupils with SEN, not only share a location, and have opportunities to socialise, with mainstream pupils; they also take part in mainstream educational programme, joining in with regular lessons on a part-time or full-time basis

Prior to the introduction of the term inclusion, ‘integration’ was used to describe the degree of mainstream provision experienced by children with SEN. In her report, Warnock (DES, 1978) identified three different levels of integration within the education system (See Table 2). Ainscow (1995) suggests that integration and inclusion differ in two ways. Integration refers to a school making some additional provision for individual pupils with SEN, with the onus being on the individual to make adjustments to fit in, rather than the school adjusting. Inclusion implies a more radical change process, where the onus is on the school to change its practice to include a child with SEN (Ainscow, 1995).

In response to the literature, summarised above, which attempts to conceptualise inclusion, and from my own experiences of working with children with statements and contributing to the statutory assessment process I propose that there are three main arguments concerning inclusion and the statutory assessment process. These are: firstly the role of statements in allowing children to access special schools or alternative provision, secondly whether the support identified in a statement is inclusive (see Section 2.1.3) and thirdly if as part of the statutory assessment process diagnostic labels are used to describe a child’s needs the impact this may have on their experience of an inclusive education (discussed in Section 2.2).

2.1.2 Placement in Mainstream or Special School?

A statement of SEN is needed in order for pupils to be educated in special schools and often specialist provision/units attached to mainstream schools. It is the placement of children with statements in special schools or units which some individuals would claim to be non-inclusive, depending on their understanding of this concept. One of the main arguments for inclusion which stems from the human rights movement, supported by the Centre for Studies in

Inclusive Education (CSIE), purports that it is a child's right to attend a mainstream school and be fully included in its academic and social processes (Mittler, 2000). Therefore it could be reasoned that whilst there are still special schools there is no need for mainstream schools to be fully inclusive, thus perpetuating further non-inclusive practice within the education system.

When criticising the 'human rights' argument for 'full' inclusion Lindsay (2003) asserts that inclusion is one of a number of competing 'rights' or values; for example it could be argued that it is a child's right to receive a 'good' education, which in some cases may be better provided through special, rather than mainstream schooling. Farrell (2000) also argues that 'full' inclusion in mainstream settings has implications for the 'rights' of other children within those settings with regard to their educational experience.

In the 1997 Excellence for All Children: Meeting Special Educational Needs Green Paper (DfEE), the government highlights the benefits of inclusion and sets out its commitment to promoting it,

“The ultimate purpose of special educational needs provision is to enable young people to flourish in adult life. There are therefore strong educational as well as social and moral grounds for educating children with special educational needs with their peers.” (p.43)

However the green paper did not advocate 'full' inclusion, recognising that the 'needs of the individual are paramount' (p.44) and specialist provision should be available where these can not be met in mainstream school.

One argument for inclusion is the research evidence which suggests children with SEN who are educated in mainstream schools make comparable progress to those in special schools. Ofsted (2006) carried out inspections in 74 schools and used case studies to compare the progress of pupils with similar needs in different types of provision and concluded that,

‘There was little difference in the quality of provision and outcomes for pupils across primary and secondary mainstream schools and special schools.’ (p. 3)

Dyson et al (2004) used end of key stage results from the National Pupil Database, in combination with cases studies, to determine the effects of inclusion on pupil attainment. They found there was no negative impact of inclusion in mainstream schools for children without SEN, and that both teachers and pupils reported positive effects on social skills and understanding. However there was some indication that having SEN may be a risk factor for isolation and low self-esteem, with pupils with SEN experiencing more difficulties in these areas than those without.

It seems that there is still a need for further research into whether education in mainstream school is truly beneficial for pupils with SEN and those without. Both Ofsted (2006) and Dyson et al (2004) suggest that it is the type of provision and factors within an individual school, rather than the needs of the child and the type of school itself that are significant in determining the progress of children with SEN.

2.1.3 Inclusion and Teaching Assistant Support

When conceptualising inclusion as more than simply education within a mainstream setting, it is necessary to consider the type of support a child with SEN is offered by their school. Some

statements indicate the extent of provision a child is entitled to either in monetary terms or in hours of support, which are often provided by a Teaching Assistant (TA). Blatchford et al (2007) report a 99% increase in TAs in England from 1997 to 2003. Although this increase is partly due to the introduction of the national literacy and numeracy strategies, it can also be attributed to the inclusion of children with SEN in mainstream schools and the contingent provision of additional support to them by TAs (Howes et al, 2003).

A number of concerns have been identified in relation to TAs supporting children with SEN in mainstream school: in particular the extent to which this amounts to inclusive practice when it can result in detrimental effects such as unnecessary dependence on adults, stigmatisation, interference with peer interactions and teacher relationship/involvement, and less competent teaching (Giangreco & Broer, 2005). Ofsted (2003) carried out inspections in a number of schools judged to be making effective provision for children with SEN, and reported that where TAs are deployed effectively, supervised by teachers and their work well planned, then they made a 'significant contribution to the overall success of lessons' (p.14) for children with SEN. However the inspections found that where schools expected too much from TAs and their work was poorly supervised, the pupils they supported made less progress. Ofsted (2003) also noted that the successful support by a TA depended on that pupil's perceptions of the TA's role, and that some secondary pupils appeared to resent the extra adult attention.

Groom and Rose (2005) used questionnaires in 94 schools and semi-structured interview in 20 of these to elicit from stakeholders (parents, teachers, pupils and governors) factors which contribute to effective TA practice in supporting children with behavioural difficulties. TAs

were recognised as contributing to the successful inclusion of children with behavioural difficulties by supervising individuals or small groups within class, supporting behaviour management plans and monitoring progress against targets, providing pastoral support and running group interventions. These findings contrast with Farrell's (2001) assertion that it is impractical to include children with emotional and behavioural difficulties in mainstream schools because of the high levels of psychological support and containment that are required. The reliability of Groom and Rose's (2005) findings could be questioned because it is unlikely that schools would identify themselves as using TAs ineffectively or being non-inclusive, especially in face-to-face interviews where anonymity can not be protected.

In a review of the literature on the use of TAs, Howes et al (2003) found that TA effectiveness is related to the extent to which they are valued and integrated as members of the teaching team and the extent to which the support they offer a pupil is inclusive, for example by encouraging interaction with the teacher and other children. This, again, brings the argument back to inclusion versus locational integration and the need for schools to adjust their practice to include children with SEN, rather than viewing additional provision, such as TA support, as a means of fitting the child into an existing school system (Lindsay, 1997; Farrell, 2000). It also highlights the variation between schools in relation to their understanding of the inclusive use of TAs and suggests that even where support from a TA within a mainstream school is recorded in a legally binding document, such as the statement, this does not guarantee that that pupil will receive an inclusive education.

Recently Warnock (2005) claimed that inclusion was a 'disastrous legacy' of her 1978 (DES) report because it undermined the role and existence of specials schools, placement options

which she now recognises may be needed in order for ‘all children to be included in their school community’ (p.41), an understanding of inclusion also shared by the National Association of Head Teachers (2003). Some researchers argue that it is difficult to establish inclusive practice within the confines of the current English education system. Norwich (2002) argues that whilst schools function within a ‘market-style system’ established by the 1988 Education Reform Act, where they have greater management autonomy, their outcome data are publicly available, and performance is judged against externally agreed standards, this has implications for the mainstream inclusion of pupils with SEN.

2.2 Labelling: The Role of Categories in SEN

Section 1.2 details how the Warnock Report (DES, 1978) recommended the abolishment of the categorisation of ‘handicap’ used within the English education system (see Figure 1); however the current SEN Code of Practice (DfES, 2001) refers to four broad ‘areas of need’: communication and interaction, cognition and learning, behaviour emotional and social development, and sensory and/or physical, recognising that children may have difficulties in more than one of these areas. When providing further guidance within each of these areas the Code of Practice goes on to refer to children with ‘specific learning difficulties, such as dyslexia or dyspraxia’, children with ‘autistic spectrum disorders’ and those with ‘moderate, severe or profound learning difficulties’ (p. 86). Hastings et al (1993) describe the frequent changes in terms and categories used to describe SEN as ‘labelling cycles’, where new terms are introduced as progressive but eventually are viewed as derogatory as the next set of new descriptors become widely used. Farrell (2001) asserts that

‘despite a long-standing dissatisfaction with a category-based system for describing different types of SEN, we find it very difficult to dispense with them.’ (p.3)

One of the fundamental disadvantages of categorisation was outlined in the Warnock Report (DES, 1978) when it recognised that children with SEN did not fit neatly into a descriptive category. Farrell (2001) develops this argument by emphasising the interactive model of SEN (Wedell & Lindsay, 1980) which acknowledges that a child's behavioural needs may result from inappropriate management at home or at school and that therefore it is unfair to label that child as having emotional and behaviour difficulties (see discussion of conceptualisation of SEN in Section 1.1). Labels, including medical diagnoses, are often argued to be disadvantageous because they limit other people's perceptions and expectations of the person to whom the label is applied. Rix (2009) asserts that labels have many different assumptions attached to them in relation to the behaviour, ability, worth and potential of a person, often making it harder for the person to be viewed as a whole. Foucault (1978), in his social constructivist approach, argued that the process of labelling acts to maintain power relationships between individuals in society, and is key in how a person's identity is formed.

There are recognised benefits to labelling/giving diagnoses; these include raising awareness of different types of SEN, reducing ambiguity and providing communication tools within professional discourse (Lauchlin & Boyle, 2007). Research has found that often parents, and children themselves, find it useful to have the problems they are experiencing recognised and given a name (Farrell, 2001; Lauchlin & Boyle, 2007). In some cases labelling provides useful information for schools and parents on strategies for meeting the child's needs and may enable the family to access support groups and additional resources (Gillman et al, 2000). However Farrell (2001) argues that it is rare for intervention strategies to be associated with

one particular label, asserting that specific teaching techniques are often recognised ‘best practice’ for meeting the needs of children with a range of different SEN.

It could be argued that the statutory assessment process perpetuates the use of labels by officially recording on statements children’s medical diagnoses or category of SEN. Additionally it could be claimed that a child going through the statutory assessment process, even if no labels are used, is stigmatised, since the process inherently draws attention to their difficulties or differences. As stated in Section 1.1, some researchers argue that the language of SEN itself reflects a deficit model (Norwich, 2002), in which case statutory assessment could be viewed as part of a stigmatising and discriminatory process. However in response to this it has been argued that without formal labels individuals will often be given an informal label (Gottlieb et al, 1994) and this may have equal or greater negative consequences. Farrell (2001) emphasises the need for all involved with a child to be aware of the negative consequences of using categories and urges that they should not be used to dismiss or excuse the failure of a child within the education system.

2.3 The Statutory Assessment Process: Cost and Allocation of Resources

Three recent reports/inquiries into the processes and provision for SEN within England and Wales by the Audit Commission (2002), Ofsted (2004) and the House of Commons Education and Skills Select Committee (2006) have identified concerns relating to the cost and effectiveness of the statutory assessment process. The Audit Commission (2002) considered a wide range of evidence, including research within five LAs, interviews with LA officers, visits to schools and review of 100 individual case files, and reported significant concerns about how well statutory assessment and statements were working, concluding that there was

a need for national debate about future reform to the statutory framework (Pinney, 2002). The report found that within the LAs visited, the statutory assessment process cost approximately £2,500 per child. On the basis that 36,000 statements were issued in 2000; this equates to a cost of £90 million annually, money which Pinney (2002) suggests could be used in different ways to meet children's needs more effectively.

The Audit Commission (2002) emphasised that the six month period during which statutory assessment takes place is too long a time in a child's education for additional funds or provision to be accessed, particularly as it is often requested on the basis that a child is not succeeding or making progress with their current level of educational provision. The Audit Commission (2002) also questioned the role of statements in the effective allocation of resources. It found that 68% of the SEN budget at the time was spent on statements (on 3% of all pupils); however the probability of getting a statement, and therefore access to this funding, varied according to the LA in which a child lived, the school they attended and degree of parental involvement.

In 2000 the proportion of children with statements varied five-fold between LAs: a trend which can only be partially explained by LA policy, such as decisions to delegate funding to schools (Audit Commission, 2002). This highlights the degree of variation there may be in the way the similar needs of any two children may be responded to and suggests that a statement does not ensure equitable allocation of resources nor equitable choice in relation to educational placement. This is supported by Ofsted (2004), who report that the proportion of children in special school placements varied tenfold across LAs. Moreover, a 10% increase in the number of children placed in independent schools from 2001-2003 could be interpreted as

a sign that some LAs do not have the provision required to meet some children's needs (Ofsted, 2004).

The House of Commons Education and Skills Committee of Inquiry into SEN considered a range of evidence from 2005-2006 relating to the statutory assessment process, including 230 written memoranda, interviews with 50 stakeholders and visits to schools within Essex. Their report provided corroborating evidence to the Audit Commission's findings (2002), identifying that statutory assessment was an expensive, lengthy and bureaucratic process, the outcomes of which were subject to a 'postcode lottery'. The report also highlighted the problem of different processes and provision amongst LAs in relation to children with statements who move between authorities. Currently these children have to be reassessed, requiring further professional time and money. The report recognises that this is particularly detrimental to populations with high levels of transience, such as looked after children, and those whose parents work for the armed forces, and recommends that the DfES consider how statements can be made transferable.

More recently, The Lamb Enquiry, Special Educational Needs and Parental Confidence (DCSF, 2009) was triggered in response to meetings with parents of children with SEN where 'significant failures' were identified in relation to providing them with statutorily required information. The report describes a culture where parents are viewed as part of the problem by schools and as a result, lose confidence in both schools and professionals. The report makes a number of recommendations with a focus on increasing communication and engagement with parents and provides a framework setting out what schools and children's services will do and what parents can expect, stating that,

‘Parents need assurance that they will be engaged in a positive dialogue with their child’s school, that relevant information will be provided and that the way schools and services operate will be transparent.’ (p.9)

It is clear from this recently published report that the Government is responding, at least in part, to the complaints of parents voiced through previous research. However the Lamb Inquiry (DCSF, 2009) does not recommended any significant changes in the statutory assessment process, its cost and equitability in provision for children with SEN.

In summary, it could be argued that the limitations of the statutory assessment process include: the degree to which it encourages inclusive practice within the education system, the use of labels and categories of need which is inherent to the process, its cost effectiveness and the degree to which it results in the fair allocation of resources. As discussed in Section 2.1, statements can provide access to education in special schools or units and may release funding for TA support for individual children within mainstream school, both of which can be criticised as non-inclusive practice, depending on how this is conceptualised (Mittler, 2000; Lindsay, 1997; Farrell, 2000). However access to specialist provision and additional support in school is also recognised as a benefit of the statutory assessment process, with Warnock (2005) identifying that the best way for some children to be included in their to community is by attending a special school, and studies suggesting that TA support can increase the success of some children in mainstream schools (Groom & Rose, 2005; Ofsted, 2003). Farrell (2001) claims that the statutory assessment process is inextricably linked with the allocation of ‘labels’ to pupils, the negative effects of which include assumptions about the person’s abilities, behaviour and potential (Rix, 2009) and which maintain power relationships between individuals in society (Foucault, 1978). In response to this, Lauchlin and Boyle (2007) suggest labelling a need can be helpful for the child and their family, providing them

with information and allowing them to access support (Gillman et al, 2000). Finally, the cost of the statutory assessment process, the degree to which it results in fair access to provision and the equitable allocation of resources, has been a longstanding criticism recognised by the Audit Commission (2002), Ofsted (2004) and the House of Commons Skills Select Committee (2006).

3. Six Current Statutory Assessment Cases: Stakeholder's views

3.1. Local Authority Context

Part of my role as a Trainee Educational Psychologist (TEP), working for the Educational Psychology Service in a West Midlands LA, is to act as the Visiting EP for one secondary and five primary schools, carrying out any statutory work they may produce. The six case studies, summarised within this report, were going through the process of statutory assessment at the time of writing, during the summer term of 2009. Of the six cases, two were within the secondary school, three came from different primary schools and one was carried out for a pre-schooler who was not yet attending any form of educational provision. These case studies give a 'snap-shot' of the variety of statutory work that may be carried out by an Educational Psychologist and are not a representative sample of the different needs of children who may require a statement. Within this section the LA's policy and practice relating to statutory assessment are briefly summarised, the case studies are introduced (see Table 3) and the reasons why they developed into statutory assessment are discussed. The views of the child, parents and SENCO/ teachers concerning why a statutory assessment was considered

necessary and what each party hopes it will bring are presented (where it was possible to elicit these views/ make contact with the stakeholder).

The LA has established its own strategy by which an equivalent amount of money can be provided to support a child without going through the statutory assessment process, known as a Provision Plan (PP). The purpose of this system is to reduce the number of requests for statutory assessment made by schools on the basis of requiring additional funding to support a child. Provision Plans allow a mainstream school to receive the same amount of funding as they would if the child had a statement, and the plan is reviewed yearly with the support of external agencies to ensure accountability. The child must first have moved through the Code of Practice Stages (DfES, 2001) of school action and school action plus, and have been judged not to be making adequate progress against their targets, despite support and intervention. The amount of money allocated to special provision for the child through their provision plan is determined by a profile of their needs, agreed by the school and a professional from at least one other agency who is involved in working with the child. Where children already have a provision plan the school or parents may request a statement if:

- a change of placement to special school is required;
- the child is in mainstream primary school but parents/ teachers feel they may need to be educated in a special secondary school;
- the parents want the child to have the additional ‘legal’ protection and extended support on leaving school afforded by a statement, and/or
- the parents wish the child to attend a school ‘over the border’ within a neighbouring LA.

The location of the schools for which I am the visiting TEP is close to the border of the LA, and with a limited choice of secondary schools in the area, two of which are large single sex schools, the option of choosing a school in a neighbouring LA is often identified by parents as desirable and appears to account for a proportion of the high number of Year 5 statutory assessments. A perception, voiced by parents during consultations, that local secondary schools are large and intimidating also appears to lead to statutory assessments with the aim of requesting special provision at secondary transfer because parents fear their child will not cope in mainstream.

The current report was written under the time constraints of working as a full-time Trainee Educational Psychologist, and hence the views of parents, children and school staff detailed within it, were collected whilst carrying out my casework, as opposed to forming a separate research study/ project. Permission to anonymously present their views on the statutory assessment process was gained from all the individuals represented within this report. The views of stakeholders, presented within this Section, were elicited in a number of different ways, either as part of casework prior to the statutory assessment being requested or as part of the information collecting process to inform the psychological advice. The views of teachers and SENCOs were elicited during consultations about the child's needs or during progress review meetings, and were written down as verbatim quotes. If parents were not present at review meetings, then I arranged to meet them at an alternative time, or spoke with them over the telephone in order to take a full developmental history of the child and to ask them what they hoped would be the outcome of a statement. A semi-structured interview format was

used with parents, and questions omitted or added depending on the information already collected whilst working with the child (see Appendix 1 for parental interview schedule).

A number of different methods were used to gain the views of the children and young people, depending on their age, understanding of language and the statutory assessment process. With the exception of Case F, I was able to explain my role and ask why the child thought the school may have asked me to work with them. I used Salmon lines (Salmon, 2003 cited in Butt, 2007) to elicit from the child what they liked and disliked about school, and then discussed this in more detail with them. We also discussed what they thought might help them in school, and whether they would want to change school. All of the information collected was recorded within the child's Educational Psychology Service File and stored according to LA policy.

The information collected for this report, and the methods used to do so, are part of the normal practice undertaken by myself in order to inform the statutory assessment process and aid the writing of psychological advice. However there are still ethical considerations which need to be taken into account, such as the power relationships which may exist between professionals, parents and children. In the current cases parents had given permission for me to work with the child in school and on a one to one basis. My role was explained clearly to both parents and children, who were given a choice concerning whether they wished to meet with me, and were assured that they could end the meeting at any time they wished. In all of the cases I made it clear that I was available to support parents, children and teachers throughout the statutory assessment process and in their decision making if a statement was, or was not, given. I was able to offer this continued support as the visiting EP for the school.

Table 3: Summary of Statutory Assessment Casework

	Case A	Case B
Age (Years)	12	10
Gender	male	male
Ethnicity	White British	White British
Who requested SA?	Secondary school	Parents
Areas of need	Behaviour Concentration Interpersonal skills with adults Learning (to a lesser degree)	<ul style="list-style-type: none"> • Learning skills • Interpersonal skills with peers • Independence/self-help skills
Relevant educational background	Attended 2 primary schools: managed move from first, permanent exclusion from 2 nd in Year 6. Aggression towards teacher Several months in behaviour unit on reduced timetable	Attended 2 different primary schools. Currently in a 'difficult' Year 5 class with a number of children with behavioural and learning needs. Has had Learning Support team involvement since Year 3
Relevant family background	Lives with mother and older siblings. Two recent bereavements within close family. Mother, whom he is very close to, is also ill.	Lives with mother, step father and two siblings. Irregular contact with Father.
Relevant medical history	none	Currently being assessed in child Development Centre. Queries over speech and language difficulties, autism and Dyspraxia
Relevant developmental history	Mother report normal development	Mother reports delayed speaking, Speech and language therapy involved from 2 years of age
Previous EP involvement	Unknown to psychology service at primary school. Raised as a concern on entering Year 7	Psychology service monitored progress at annual meeting with the school, no involvement until request made
Other services involved	PSSS, BSS	PSSS, SALT Community paediatrics
Summary of needs/ presentation within school	Frequent refusals and defiance to school staff. Poor concentration, leaves lessons without permission and runs around the school. Immature	Poor understanding of language in school and slow progress with high levels of support. Some immaturity in relation to interactions with

	behaviour and interactions with other pupils.	peers.
	Case C	Case D
Age (Years)	9	9
Gender	female	Male
Ethnicity		White British
Who requested SA?	Primary School	School
Areas of need	Learning Behaviour Interpersonal skills with adults and peers	<ul style="list-style-type: none"> • Behaviour • Concentration • Interpersonal skills with adults and peers
Relevant educational background	Attended the same school since nursery. Has had external agency involvement since Year 2: Behaviour Support and Communication teams.	Joined current school in Year 2. Previous school attended from nursery but was on a reduced timetable of half days during reception and Year 1.
Relevant family background	Lives at home with parents and younger sibling.	Lives with young mother and her partner. Irregular contact with father, no siblings.
Relevant medical history	On medication for epilepsy, currently being assessed for autism, diagnosis of dyspraxia. Medicine recently reviewed, no fits in school this year.	Diagnosed with ADHD, trialled on medication but mother withdrew treatment due to an allergic reaction. Missed appointments at child development centre- now re-referred.
Relevant developmental history	Delayed milestones, although difficulties not apparent till started nursery	Mother reports normal development
Previous EP involvement	Monitored until raised as a concern at the beginning of Year 4	No known involvement at previous school. Supported over 2 years by EPS in current school.
Other services involved	PSSS, BSS, CAT Community paediatrics	Community paediatrics CAMHS referral Social services support for mother
Summary of needs/ presentation within school	Avoidance of work, high level of attention seeking from adults. Frustration with work expressed through aggression towards teachers. Opts out when challenged. Poor social skills	Poor concentration and disruption in lessons, leaves class and hides around school premises. Becomes very distressed, often screaming for up to 40 minutes. Aggressive towards peers.

	Case E	Case F
Age (years)	12	2
Gender	Male	Male
Ethnicity	White British	White British
Who requested SA?	School	Trainee Educational Psychologist
Areas of need	Behaviour Interpersonal skills with adults and peers	<ul style="list-style-type: none"> • Visual impairment • Language • Early learning skills • Interpersonal skills
Relevant educational background	Withdrawn from primary school in Year 6 and tutored at home because mother disagreed with a multicultural assembly.	Nursery placement organised by social services attended for 6 weeks. Currently attending community play and stay mornings
Relevant family background	Lives with mother, 2 older siblings and 1 younger. No contact with father.	Looked after child due to neglect and inconsistent care, one of five children, 3 of whom are under the age of 3 years. Short term foster placement with older sibling with same visual problems.
Relevant medical history	Support during primary school from CAMHS- mother reports self harm and attempted suicide. Spine condition limiting sport that can be played	Involvement of Community Paediatrics.
Relevant developmental history	Mother reports normal development. Behaviour always been challenging but got worse following spine injury.	Social services reports of neglect, under feeding, domestic violence and postnatal depression
Previous EP involvement	No involvement at primary school. Referral on entry into Year 7 at Secondary school	None
Other services involved	CAMHS, BSS	Social services, SALY Visual impairment Team Community paediatrics
Summary of needs/ presentation within school	Threatened physical aggression towards teachers and actual peers. Poor concentration, and disruption within lessons. Abusive language used with adults and peers.	Intent to communicate but poor language, few naming words. Poor learning and play skills, for example posting shapes. Isolated play when in the company of peers.

SALT= Speech and Language Therapy, EPS= Educational Psychology Service, ESS- Early Support Service
CAT-communication autism team, PSSS= Pupil and School Support Service, BSS= Behaviour Support Service,
CAMHS= Child and Adolescent Mental Health Services

3.2 Reasons for Requesting a Statutory Assessment

Of the six case studies the three children at primary school were on PPs, and had been for at least a year when a statutory assessment was requested.

In case B the pupil had been on a PP for a number of years, so the school had been receiving the same funding as they would have if he had been statemented. Although there was no change in B's needs his mother requested a statutory assessment because she was concerned about his poor progress, despite intervention, and how he would cope in secondary school. B's mother was considering a local special secondary school as well as a private school specialising in dyslexia.

In case C the school and mother both shared concerns about C's progression to secondary school (currently in Year 4); however the school was also struggling to manage C's current behaviour and suggested that a change of provision may be needed before the end of Year 6.

In case D the school lead the request for the statutory assessment, arguing that they were unable to manage D's behaviour in school and that he was close to permanent exclusion. Although D's mother agreed to the assessment, she made it clear that she was not in agreement that he needed special school education (see Figure 3).

The requests for statutory assessment from the secondary school were related to staff not being able to manage the behaviour of the young person in cases A and E. Both of these boys were in Year 7 and had been in the school for a period of less than 3 months when the school raised concerns about their behaviour and suggested that a special school may be a more

suitable placement for them (see Figure 6). Child E was educated on a temporary basis in a Pupil Referral Unit for children with behaviour difficulties whilst the statutory assessment took place, and child A remained in mainstream school on a reduced timetable. In both cases the school requested statutory assessment; however in case A the mother later expressed disagreement with this decision (see Figure 3).

In case F I requested a statutory assessment with the agreement of all the professionals involved in the case. Case F could be viewed as more ‘clear cut’ in relation to whether the child required a statement because of his visual impairment, which places him in the ‘low incidence/ high cost’ funding criteria for children with medical needs, visual and hearing impairment. Child F’s case is also made stronger by the fact he is a ‘looked after child’ and therefore may be more vulnerable to poor educational outcomes and so is prioritised by both national and local policy (DfES, 2007).

Within this sample of six diverse cases, requests for statutory assessment are the product of a number of influential factors, rather than one in isolation. For example in case B it was a combination of parental concerns about the future, feedback from the school about B’s lack of progress against PP targets and new diagnoses given by doctors at the Child Development Centre that resulted in the mother requesting a statutory assessment. However amongst the six case studies the main reasons for requests are requests for changes in placement from mainstream to specials school (A,E,D) concerns about the child moving to secondary school and wishing to have the option of special school placement (B,C, and because of medical needs (F). Interestingly these views are not equally shared by all the stakeholders; for example in Cases A and D the school wanted a statement because they believed the pupils needed

special school education, whilst the mothers were seeking additional support within mainstream schooling.

3.3 Stakeholders' Views on the Difference a Statement will make for the Child

Parents' views concerning what a statement would bring their child and why a statement was needed contrasted in several ways. Most of the parents wanted a change in the educational provision their child received; however these parents could be split into two distinct groups; those who wanted their child to be educated in a special school (B, E, C, F) and those who wanted the school the child currently attends to do more to meet their child's needs (A, D) (see Figure 3). Interestingly neither of the parents who wanted the school to do more to help their child specifically identified additional adult support in the classroom; however both mother and child in case C felt that this may be useful whilst the child remained in a mainstream setting.

Expressed by many of the parents, either directly or indirectly, was the hope that a statement would protect their child, by providing more choice over educational placement or by ensuring their current school is giving them all the support possible and has the funding to do so (See Figure 4).

Interestingly the parents of children A and E, who did not agree with the schools' perceptions of their child's difficulties and expressed uncertainty about the need for a statement, both wanted changes in the way the schools currently provided for their child. In contrast to the other parents, the fact that a statement made available the option of attending special school was perceived as negative, rather than positive.

Figure 3: Parents’/ Carers’ Reasons for/ against Requesting a Statutory Assessment

For:

‘He needs protection, he would sink in a mainstream school’ (B)

‘Initially wanted statement for funding so he will be protected at XXXXX [mainstream secondary school] but the more doctors who work with him the more problems that are being found.’ (B)

‘I’m worried about E’s ability to be violent, someone had given him a knife and I had to take it off him.’ ‘His behaviour has got worse, even at home.’ (E)

‘C has had problems from day one of nursery.....numerous interventions and strategies have been tried, these seem to work for a few weeks then they stop and she ends up hitting children/teachers, unwilling to work and disruptive.’ (C)

‘F has had limited opportunities to learn through play and interact with other children, he is already developmentally behind, we need to get him into a Visual Impairment Special school as soon as possible so he has a chance of catching up.’ (F)

Against:

‘I don’t struggle with him at home like the school does but I feel he doesn’t understand his behaviour as he does it again after being punished.’ (D)

‘He hates school; he says he’s going to be naughty so he can be sent home.’ (D)

‘School have put him in stupid classes- for a 6 year old, he’s bored out of his mind so misbehaves. Considering everything he’s been through he’s doing ok, a bit over active.’ (A)

‘Why do you want to statement him? My older son was statemented after being bullied for 5 years, it did nothing for him- you just want your pay cheque at the end of the day.’ (A)

Figure 4: Parents'\Carers' Hopes in Relation to the Benefits a Statement will Bring their Child

'I want to give him the best start I can properly give him, to protect him as long as possible' (B)

'School can't meet his needs currently, but a statement will bring more money.' (B)

'I am not an expert in this field and do not know what kind of help may assist her in school, what I am sure of is that if help is not given C will feel more and more alienated both socially and academically.' (C)

'I don't want D to go to naughty school, because he's bright and will be influenced by the other children.... feel school needs to do more, like distracting him, giving him a job when he has a tantrum.' (D)

'I have no idea what he needs; I want him to stay in mainstream if possible. I know what he's like and if he goes to a behaviour school he will be influenced by the other children and come out with nothing.' (E)

'He's made such good progress, I don't think he should go to special school just because he's a looked after child.' (F)

When eliciting the children and young people's views it was clear that the majority of the children, even those in secondary school, had a very limited concept of the statutory assessment process and what it would mean for them to have a statement. Statutory assessment is, of course, a difficult concept for a child to understand; however even when described in terms of extra support in school and the opportunity to attend different types of school, many of the children were unaware that the process was happening to them. The children were able to express what they felt they needed in school (E, C, D) and a preference about whether they wanted to go to a different school or stay where they were (B, E, A) (see Figure 5).

Figure 5: Children's Hopes/ Perceptions of What a Statement will Bring

'I have made my decision, I want to go to XXXX because I already have a friend there' (special secondary school) (B)

'I want to go to a mainstream school, not a behaviour one; mum wouldn't let them send me anywhere like that' (E)

'It would be good if I could stay here [behaviour PRU] then go straight to college. It's smaller here and the teachers don't shout' (E)

'More teachers to look after me, classroom too noisy.' (C)

'I want to stay in this school [mainstream]; my mum wants me to as well, but the work they give me now is for babies- my 3 year old cousin can read those words and she learnt off the telly' (A)

'This is how I feel when I get excluded, but not when I get home' (D) [pointing to a picture of a sad tree/blob person]

(Child F's views could be ascertained because of his age and speech development)

The majority of the views expressed by class teachers or SENCOs related to the school not being able to meet the needs of the child and so, directly or indirectly, supported change in placement. None of the school staff argued that a statement would bring additional funds allowing them to support the child further within their current placement. In some cases this is due to the fact the child was already on a provision plan and the school was receiving all the funds they could for them; however in other cases, such as A and E, the school staff were suggesting that special school provision was needed to meet the child's needs. Interestingly half of schools referred to the effects the child's difficulties were having on members of staff and other pupils (D, C, E) rather than on the child's own progress or well being.

Figure 6: Teachers’/ SENCOs’ views on why the child needs a statement

‘Behaviour not compatible with the effective education of others in a mainstream setting at this time. School can not offer the supervision or support necessary for him; his attitude and behaviour leave him in serious danger of permanent exclusion.’ (E)

‘There has been some improvement in his behaviour but still follows his own agenda, on his own terms.’ (A)

‘The school feel all levels of support have been offered. A struggles to manage his behaviour and requires one to one support at all times.’ (A)

‘We are worried about her lack of progress academically and socially. She is opting out of work and frequently demands attention from the adults in the classroom- we are especially worried about secondary transfer- she won’t cope in a mainstream secondary school. (C)

‘He hurts children, every lessons he is abusive to certain children- he picks out the vulnerable ones. He is constantly disruptive, wailing for up to 30 minutes in the corridor. Its unfair on the other children and on the teacher.’ (D)

4. Research on Stakeholders’ Views of Statutory Assessment

4.1 Parents’ Views of Statutory Assessment

The Audit Commission (2002) report that parents often had negative experiences in relation to having their child’s needs recognised; many felt they had to fight in order for the statutory assessment process to be started. The exceptions to this were cases where the child’s needs were viewed as ‘clear cut’, such as profound and multiple learning difficulties (Pinney, 2002). Parents expressed frustration about the volume of different information they received, its usefulness and the jargon used by professionals,

‘The jargon was baffling – they tell you “it’s going to panel” – it feels like you’re following the file around the office!’ (Pinney, 2002, p.119).

A similar sense of frustration was recorded in the House of Commons Education and Skills Inquiry Committee Report (2006) which asserted that it was unable fully to represent the 'sense of injustice and anger' (p.41) expressed by many parents of children with SEN. Parents felt that statements could be inaccurate and that the professionals contributing to them were biased and not sufficiently independent from the LA. The description of provision within the statement was viewed as insufficiently detailed, allowing LAs to avoid fulfilling their responsibilities, and often choice of educational placement was limited by the Authority's willingness to fund places either within a special school, or provide additional funding to allow education within mainstream school.

The Audit Commission report (2002) also found that one of the key factors in whether a child received a statement or not was parental influence. Many of the parents identified that their assertiveness, for example paying for a private psychological assessment or threatening the LA with legal action, played a part in securing additional funding and support for their child (Pinney, 2002). Once a statement had been obtained parents expressed that it did not always bring the assurance that they had expected, and some reported actively monitoring the school to ensure they were providing the support outlined in the statement. Within the House of Commons report (2006) parents expressed concern over how placement decisions were made within LAs, and many recounted frustration that their child was educated in mainstream school until they fought for a special school placement and vice versa. The report emphasises that parents have a right to 'seek' a special school place; however this is not a guarantee, which can be unclear and confusing for parents. Parents reported that they felt that ultimately they had little choice as to where their child was educated,

‘either because of mainstream schools not having appropriate resources to take their child, or because special schools were not being made available to them.’ (p. 48).

It could be argued that parental appeals to the Special Educational Needs and Disability Tribunal (SENDIST) provide a source of evidence about parents’ views on statutory assessment. The House of Commons Report (2006) details that there were 3,354 appeals to SENDIST in 2003-04, with an increase of 70% since 1993-94. The majority of the appeals were against refusal to carry out statutory assessment (40%) or against the content of the statement (50%); however the total number of appeals represents less than 1% of all children with statements. In contrast to the frustration expressed earlier in the same report about lack of choice in provision, less than 1.5% of the appeals related to change, or choice, of school. Differing conclusions could be drawn from these findings; the low number of appeals in relation to the named school on a statement may reflect the limited choice available to parents within their LA; however the low percentage of appeals amongst all children with SEN could suggest that the parents’ views recorded within government reports, such as the Audit Commission (2002), are representative mainly of those who have had negative experiences of the statutory assessment process, and so responded to requests for feedback.

O’Connor et al (2005) carried out research in Northern Ireland to gain parents’ view of the statutory assessment process. Questionnaires were filled in by 1054 self-selected parents of children with current statements, 96 of whom were randomly chosen to take part in telephone interviews (with equal representation from those who expressed dissatisfaction and satisfaction with the statementing process in the initial questionnaires). Many of the statutory assessment procedures in Northern Ireland are similar to those in England, with the exception

that their Code of Practice has retained five stages of intervention, as opposed to three. The research found that the majority of parents were satisfied (81.8%) that the reports gave an accurate description of their child's needs and 54.2% were satisfied with the overall assessment procedure. 72 parents did not agree with the school named on their child's statement, and this was due to them wanting either a mainstream placement when a special school was named or vice versa. Only 11 parents reported appealing to SENDIST, of whom four had their cases heard, resulting in two changes in educational placement. Overall 74% of parents felt the statement had benefited their child and 60% felt it has also benefited them.

Parents suggested that the statutory assessment procedure could be improved by reducing the time taken to complete the process, improving communication between parents and the professionals involved in the process, giving greater consideration to parents' views, and greater accessibility to information, for example results from assessments, information on parents' rights and the services that are available to them (O'Connor et al, 2005).

4.2 Children's Views on Statutory Assessment

When carrying out the literature search in order to write the current report I found there was very little research on children's experiences of the statutory assessment process or their perceptions of having a statement. The House of Commons Report (2006) reemphasises the government commitment to representing the voice of the child in line with the UN Convention on Rights of the Child (Article 12) and asserts that

‘There has been a marked increase in including the voice of children with SEN or disabilities at a range of levels.’ (The House of Commons, 2006, p.36)

However the report itself does not include the views of children; rather it refers briefly to two studies being carried out concurrently which report on the views of children with SEN.

Norwich and Kelly (2004) carried out research on inclusion with children aged 10-11 and 13-14 years who had statements for moderate learning difficulties. They reported that the majority of children were positive about their school and the teaching they received; however a significant minority expressed mixed views. A significant proportion of those taught in mainstream schools identified that they preferred to be taught in a withdrawal setting, whilst a significant number of those taught in special schools asserted that they would prefer to be in mainstream settings. A high incidence of bullying was reported, no matter which setting the children were educated within; however those attending special school were more likely to be bullied by peers from their local community, rather than pupils within their school. Although this research gives some indication of pupils' views in relation to type of school and how they prefer to be supported in mainstream school, it does not specifically elicit their views about having a statement. Neither can a causal relationship between having a statement and being bullied be concluded, as the children involved in the study who are classed as having moderate learning difficulties, were not an homogenous group and were likely to have varied in the presentation of their difficulties and their social skills, amongst other factors.

In summary although there seems to be research on gaining children's views within the wider field of SEN, there appears to be a very limited amount on children's perceptions of statements, something which O'Connor et al (2005) in their study on parents' views of statutory assessment aptly describe as a 'dearth of research' (p.251).

4.3 Teachers' and SENCOs' Views on Statutory Assessment

SENCOs and other professionals such as Educational Psychologist have reported that rarely does the statutory assessment process reveal any additional or new information, but that the exceptions to this are rare occasions when a child is new to the LA or there is a sudden change in need (Audit Commission, 2002). SENCOs also expressed that statements do not help them meet the child's needs any more than the existing IEP they were using; however they did identify that advice from external agencies could be helpful, although this did not come exclusively through the statutory assessment process (Pinney, 2002).

Again there appears to be little research focussing specifically on teachers' and SENCOs' views of statutory assessment. However there is research on teachers' views of inclusion and their perceptions of their own ability to teach children with SEN, both of which could arguably be related to their conceptualisation of statutory assessment. Hodkinson (2005) carried out research with teachers in their final year of training and found that they had complex and diverse understandings of inclusion, the majority of them defining it according to the child's needs rather than the school's practice. 73% of the trainees expressed that they supported the concept of full inclusion; however 54% believed that in practice not all children could be included in mainstream school and that full inclusion may have a negative effect on the education of the majority.

The Audit Commission (2002) interviewed 40 SENCOs who expressed that they felt many of their colleagues lacked confidence in teaching children with SEN; this finding has been reproduced in other studies (Dockrell & Lindsay, 2001). A survey carried out by the Times Educational Supplement (14th October, 2005) found that over a third of teachers had received

no training on teaching children with SEN, and a third of teachers had received no more than a day's training during their initial teacher training course. In contrast to this Hodkinson (2005) reported that the majority of final year trainee teachers felt confident in their ability to deliver an inclusive education; however this perception may well be altered through an extended period in the actual job.

Where teachers feel unconfident about their ability to meet the needs of children with SEN and hold the view that the inclusion of some children in mainstream school adversely affects the education of the majority, this could influence their hopes and perceptions of the difference a statement will bring. For example a teacher may feel unsure about how to meet a child's needs in the classroom and so believe that their needs would be better met in a special school, rather than seeking a statement in order to receive further funding to support the child in mainstream school.

5. Discussion

The aims of this report were to outline the historical context and development of SEN policy and practice within England and Wales and review literature on criticisms of the statutory assessment process. The report then presents the views of stakeholders going through the statutory assessment process in order to understand why the process was initiated and what the stakeholders hoped a statement would bring to, or change, in the education of their child. Within this section the views of the stakeholders from the case studies are discussed in relation to the previously reviewed research on the criticisms of statutory assessment (see Section 2 and 4).

It is important to understand the influence of LA policy and practice on stakeholders' perceptions of what a statement will bring the child. I would argue that the use of PPs within the LA where the case studies are based, acts to limit stakeholders' understanding of statements as supportive of children's inclusion in mainstream school. This is because PPs allow schools to access the equivalent amount of funding a child would receive if they were on a statement, the aim of which was to reduce the number of requests for statutory assessment. As a result of this, when requests for statutory assessment are made by schools, or indeed parents, the purpose of the request is often change in placement from mainstream to special school. Within the case studies this was the school's intended outcome in three of the six cases (E, A, D), with a statement opening up the possibility of special school secondary placement in a further two cases (C, B).

There were clear differences between teachers' and SENCOs' reasons for requesting a statement and parents' understanding of what a statement would bring for their child. As discussed above the majority of schools' requests were based on the belief that the child's needs would be better met in special school. In contrast to this, parents' reasons for requesting a statement related to them wanting more additional support for their child, although not specifically through special school education, protecting their child and accessing greater choice in secondary provisions, whether this be within mainstream schools in a different LA or special school. For some of the parents (A, D, F), the fact that a statement meant their child could be educated within a special school was viewed as a negative outcome of the process; they felt this was not necessary to meet their child's needs and expressed concerns about negative role models and poor learning outcomes associated particularly with special schools for children with behavioural difficulties.

It could be argued, based on the case studies, that the statutory assessment process is being used in a non-inclusive way to move children from mainstream to specialist provision. It appears that in many cases (A, D, E and C) statutory assessment has been requested because inclusion is no longer working, which could arguably be linked to Norwich's (2002) assertion that whilst schools are subject to league tables and inspected on performance outcomes then it is impossible for some children with SEN to be included in mainstream school. Indeed, if inclusion is conceptualised in the same way as Warnock (2005) and the National Association of Head Teachers (2003), where children feel included and are able to contribute to school life, then it may be that in some of these cases the child would be better included within special school.

The hopes of parents in the case studies contrast with some of parental views and experiences reported in the literature on statutory assessments. For example one of the desired outcomes of a statement expressed by the parents was knowing their child had protection; however the Audit Commission (2002) reported that parents felt a statement did not bring the assurance they thought it would, with many feeling that they had to closely monitor their child's school to ensure they got the support they were entitled to. Furthermore there is evidence to suggest that statements have little effect in protecting children from exclusion, with one study reporting that children with statements are seven times more likely to be permanently excluded than their peers (Hayden & Dunne, 2001). In addition to this parents' perceptions that a statement will provide them with greater choices in relation to where their child is educated may also be misconstrued, with the House of Commons report (2006) suggesting

that many parents of children with statements were unhappy with LA placement decisions and ultimately felt they had little choice.

It is unclear what role labels or diagnoses played in the decisions of stakeholders in the case studies to request a statutory assessment; however in five of the six cases labels had been given to the child or were in the process of being investigated. Where diagnoses or labels are recorded in a statement these will remain with the child for the rest of their education, unless they no longer apply and are removed during an annual review. It could be argued that the use of labels, and the concept that a statement in itself may act as a label, could be influential in teachers' and SENCOs' perceptions of statements. Although there is little direct research on teachers' views of the statutory assessment process, the literature summarised in Section 4.3 indicates that teachers have mixed views on the inclusion of children with SEN, and some report lacking in confidence and training in relation to teaching these children (Dockrell & Lindsay, 2001). Where children have a statement teachers may hold lower expectations for them, feel less confident in supporting them within the classroom, and therefore be less likely to persevere when it appears little progress is being made. Further research would need to be carried out in this area to determine the extent to which this may be true, and if such an effect varies depending on the reason why a statement has been given.

There was a startling lack of research on children's perceptions of statements and the statutory assessment process, despite claims that there has been a marked improvement in representing views of children with SEN (House of Commons, 2006). Although, within the current LA, it is common practice for the views of children to be recorded on paperwork such as annual review forms, these views often relate to what the child thinks would help them in school or

what they are doing well at, rather than eliciting their views of the processes and purposes of statutory assessment. When working with the children in the case studies I felt that the statutory assessment process was something which was being done to them, without their consent or understanding. Even with those children who were old enough and able to understand the concept of a statement and what it may bring, it appeared that no-one had explained the process to them in an accessible way. Interestingly, with two of the parents (D and A) it seemed as if they had little choice in the process either, with the school suggesting that a statutory assessment should be carried out or the child would be permanently excluded.

It could be argued that the six case studies provide further support for criticisms relating to the length of time it takes for a statutory assessment to be carried out and the cost of this process in terms of money and professionals' time. Although none of the parents complained that statutory assessment should have been initiated earlier for their child, it could be argued that in five of the six cases the children had experienced significant failure at school before the process was initiated. Where the process then takes a further six months, this delay is likely to compound the child's difficulties and negative experiences of school. This is evident in case E where the child was educated in a Pupil Referral Unit for two hours per day, whilst the assessment was carried out and a placement decision made. Where a special school is filled to capacity and a child has to wait until a place becomes free, this further increases the length of time they have to remain in a mainstream school which is not meeting their needs.

The views of parents and teachers represented within this report are specific to the LA; influenced by its policy and the type and variety of mainstream and special schools within the area. Concerns were raised by parents about the limited choice of secondary schools, and the

perception that many of them were large places where their children would struggle, particularly those with poor social interaction skills. There may be other LA factors which influence parents', SENCOs' and teachers' conceptualisation of statements; for example the relatively high number of special schools within the area may feed the perception of availability of special placements, and the idea that if these schools are available they should be used.

5.1 Implications for the Practice of Educational Psychologists

The findings from research on parents', children's and teachers' views of statutory assessment, reviewed in Section 4, in combination with those represented in Section 3, have implications for the practice of Educational Psychologists (EPs). Currently EPs have a mandatory role in the statutory assessment process by contributing their psychological advice, which summarises the child's educational needs and the provision required to meet these. Although the importance of EPs' work beyond individual casework and writing psychological advices has been recognised by the DfEE (2000) and DfES (2001), and there is some evidence to suggest that contribution to statutory assessment is taking up less of EPs' time (Farrell et al, 2006), it still remains a core activity for the profession.

EPs can play a role in challenging the belief, reported by teachers and SENCOs in the case studies, that some children's needs would be better met in a special school, rather than the mainstream school they currently attend. From my experience of working with the six cases presented in this report, such a belief is not based on teachers' knowledge of local special schools and the children who attend them, but rather on their experience of struggling to meet the child's needs. This opinion may also be underpinned by the lack of confidence and

training in relation to teaching children with SEN reported by some teachers (Dockrell & Lindsay, 2001). When working with teachers who are challenged by the learning or behavioural needs of a child in their class EPs are in a position to contextualise and normalise that child's needs within the LA context, providing anecdotal information on strategies that other teachers have found helpful, as well research evidence on effective interventions. EP's knowledge of LA policy and specialist provision available enables them to discuss with teachers whether a child meets the criteria for a statement or special school placement.

Where parents and school staff have differing or unrealistic opinions on what a statement will mean for a child EPs are in a position to ensure that information relating to the statutory assessment process and its outcomes is presented clearly and accessibly to all parties involved. For example, if parents want a statement in order for their child to have more adult support in the classroom then the EP can discuss with the parents both the benefits and disadvantages of TA support, and how this may affect their child's inclusion in school life. EPs, along with the advantages of a statement, can also raise the disadvantages it might bring, such as 'labelling' the child and influencing teachers' expectations in relation to their behaviour or learning. Similarly, where schools are requesting a statement with the aim of providing a child with high levels of TA support, EPs can challenge the effectiveness of such support and the extent to which it may limit the social inclusion of the pupil. Through their on-going work with schools EPs have the opportunity to work proactively to educate schools about the role of statements, and to provide training for staff to increase their confidence and skills in relation to meeting the needs of children with SEN.

Finally, in the current report, where pupils' opinions about the statutory assessment process could be ascertained, it was evident that they knew little about it and the possible consequences should they be given a statement. When working with individual children whose needs may result in statutory assessment, EPs have the skills and experience to elicit such children's views on school, their needs and the type of support they find useful, and to represent these to teachers and parents to ensure the child's voice is heard. Where EPs are limited in the time they have available to work with an individual child, they can support the school, through training or provision of materials, to elicit the child's views and share with them, in an accessible way, the statutory assessment process.

6. Conclusions

In conclusion, from the limited published research on this area, it appears that the practice of statutory assessment and the administration of statements remains contentious. The views of parents, from the case studies represented within this report, and their expectations in relation to what a statement would bring their child, differed from the realities reported by parents in existing literature, suggesting that they too may be joining the numerous parents voicing dissatisfaction with the procedure. It can be concluded from the case studies that there are still grounds to criticise the inclusiveness of the statutory assessment process and question how schools and teachers perceive children with statements of SEN. In light of the Audits Commission's call for a review of SEN procedures (2002), which was supported by the House of Commons report (2006), it would be valuable for further research to be carried out on stakeholders' perceptions of statements and the statutory assessment process, in order to inform any changes to the framework for assessing SEN.

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Appendix 1

Semi-structured Interview Schedule used with Parents to Elicit Their Views about, and Expectations of, the Statutory Assessment Process

With your agreement I am going to ask you some questions about X, his/her developmental history and any relevant family background information, in order to describe his/her needs fully in the psychological advice I am writing to contribute to the statutory assessment procedure.

I would also like to ask you about your perceptions of X's needs and what you hope a statement would bring or change for him/her. If there are any questions you do not wish to answer then please say so. The information you give me will be used to write my report and will be stored in X's Educational Psychology file. With your permission I would like to anonymously report the answers to questions 8,9 and 10 in a report which I am writing as part of my training to become a qualified Educational Psychologist. Is that ok? Do you have any questions you would like to ask me?

1. Did you have a normal pregnancy and labour with X?
2. As a baby did X reach his/her developmental milestones within a normal time limit? e.g. crawling, walking and speaking.
3. Did X have any significant childhood illnesses or injuries?
4. Did X attend a nursery/ playschool? If so, for how long? Did they settle there? Was any additional support provided for them by the early years provision?
5. When did you begin to notice that X had additional needs? When did you become concerned about X's behaviour/learning/development/ social interaction etc?
6. How do X's needs affect home life? How do you manage their needs at home?
7. Is X currently being seen or monitored by any other services? e.g. Speech and Language Therapy, Doctors
8. Do you feel X's needs are being met in school currently? What do you think is working and what do you think could be improved?
9. Why do you think/disagree that X needs a statutory assessment? /Why have you requested a statutory assessment take place/why have you supported the school's request for a statutory assessment?
10. What difference do you think a statement will make for X?

(shaded questions were asked to inform assessment and psychological advice)